Prepared by the North Dakota Legislative Council staff for the Health Care Reform Review Committee

June 2011

IMPACT OF FEDERAL AFFORDABLE CARE ACT - BACKGROUND MEMORANDUM

INTRODUCTION

Section 1 of House Bill No. 1252 (2011) (Appendix A) directs the Legislative Management's Health Care Reform Review Committee to monitor the impact of the Patient Protection and Affordable Care Act (PPACA). If a special session of the Legislative Assembly is necessary to enact legislation in response to the federal legislation, the committee is directed to report to the Legislative Management before that special session.

Committee Studies

The Legislative Management has charged the interim Health Care Reform Review Committee with performing three studies--this study, as well as a study of the impact of the PPACA on the Comprehensive Health Association of North Dakota (CHAND) and the statutes governing CHAND and a study of the feasibility and desirability of developing a state plan that provides North Dakota citizens with access to and coverage for health care which is affordable for all North Dakota citizens, as provided by directive of the chairman of the Legislative Management.

Committee Updates

In addition to the committee's studies, the Health Care Reform Review Committee is charged with receiving the following updates:

- Regular updates from the Insurance Commissioner during the 2011-12 interim regarding administration and enforcement of the PPACA, proposed legislation for consideration at a special legislative session, and proposed legislation by October 15, 2012, for the 2013 regular session (2011 House Bill No. 1125, Section 2);
- Regular updates from the Insurance Commissioner and Department of Human Services during the 2011-12 interim on planning and implementing an American health benefit exchange for the state and proposed legislation for consideration at a special legislative session, or proposed legislation by October 15, 2012, for the 2013 regular session (2011 House Bill No. 1126, Section 3); and
- Regular updates from the Insurance Commissioner during the 2011-12 interim with respect to steps taken to ensure health insurer procedures are in compliance with the PPACA, proposed legislation for consideration at a special legislative session if the commissioner is required by federal law to implement any requirement before January 1, 2013, and proposed legislation by October 15, 2012, for any requirement that must be implemented between January 1, 2013, and January 1, 2014 (2011 House Bill No. 1127, Section 6).

BACKGROUND

Affordable Care Act

In March of 2010 President Barack Obama signed into law two pieces of legislation that laid the foundation for a multiyear effort to implement health care reform in the United States--PPACA (H.R.3590) and the Health Care and Education Reconciliation Act of 2010 (H.R.4872)--which together are referred to as the Affordable Care Act (ACA). The Affordable Care Act crafted new structural models to increase access and affordability of health care coverage, with as many as 32 million additional Americans being covered; to improve operational governance of the health insurance industry; to provide consumers protection; and to provide new tools for the improvement of the health care delivery system and patient outcomes.

Of particular interest to states regarding the ACA are the multiple specific provisions of the ACA and the implementation timeline of these specific provisions. The Henry J. Kaiser Family Foundation document "Summary of New Health Reform Law" published April 19, 2011, provides a summary of the multiple provisions of the ACA. This document is attached as Appendix B. Additionally, the United States Department of Health and Human Services has published a timeline of implementation of the ACA. A copy of that timeline is attached as Appendix C.

The National Conference of State Legislatures has identified and summarized the following ACA provisions and dates as being of interest to state legislatures:

2010

- High-risk pools established by states or federal government.
- Small business tax credits offered for employees' health coverage.
- Insurance companies required to cover young people to age 26 on their parents' plans.
- Prescription coverage gap for seniors reduced.
- Federal grants awarded to states for insurance premium reviews, health insurance exchanges and other programs.
- Insurance companies restricted from dropping coverage for people who get

sick or excluding coverage for kids with pre-existing conditions.
- States offered option to expand Medicaid earlier than 2014 to cover adults with incomes up to 133 percent of poverty, at the state's regular Medicaid matching rate.

2011-2013
- Medicare reforms required, such as ensuring access to physicians, improving payment accuracy and prescription drug coverage.

2014
- Medicaid must cover an estimated 16 million additional people by 2017.
- Health exchanges start, with federal subsidies to help middle-income Americans purchase coverage.
- Individuals must purchase health insurance, with some exceptions.
- Insurance companies must cover people with pre-existing conditions and policies must be renewed even if people get sick.
- Employers with 50 or more full-time employees must offer coverage or pay a fee.

2016
- States have option to join multi-state compacts.

2018
- High-cost or so-called "Cadillac" health plans will be taxed.

2009-10 Interim Industry, Business, and Labor Committee Study

During the 2009-10 interim the chairman of the Legislative Management directed the interim Industry, Business, and Labor Committee to monitor federal health care reform legislation, including its effect on North Dakota citizens and state government; the related costs and state funding requirements; related tax or fee increases; and the impact on the Medicaid program and costs, other state programs, and health insurance premiums, including the Public Employees Retirement System (PERS).

The interim Industry, Business, and Labor Committee received testimony from a wide range of interested parties, including representatives of the:
- Insurance Commissioner;
- Department of Human Services;
- PERS;
- State Department of Health;
- Tax Commissioner;
- Bank of North Dakota;
- Cato Institute;
- George Mason University Center for Health Policy Research and Ethics;
- Pharmaceutical Research and Manufacturers of America;
- Cameron Institute;
- Health Services Management Programme at McMaster University located in Hamilton, Ontario;
- North Dakota Medical Association;
- North Dakota Hospital Association;
- North Dakota Pharmacists Association;
- Blue Cross Blue Shield of North Dakota; and
- Business owners and farm groups.

The interim committee recommended House Concurrent Resolution No. 3003 to direct the Legislative Management to continue studying the impact of the ACA during the next interim. Although the resolution was adopted, the Legislative Management did not prioritize the study.

The chairman of the committee developed and the committee approved the following summary, which identifies the anticipated costs to the state of implementation of the ACA:
- State population - 645,000.
- Number of residents without insurance - 45,000 (7 percent):

  15,000 (2.3 percent) qualify for current programs (Medicare, children's health insurance program, Comprehensive Health Association of North Dakota, etc.) but have not applied.

  15,000 (2.3 percent) select not to be covered by an employer or the individual market due to cost but have the capacity to afford coverage.

  15,000 (2.3 percent) are uninsured due to preexisting conditions, lifetime maximum, etc.
- Assumptions used in developing cost matrix:

  Cost increases limited to federal health care bill only - No inflators applied for increases in health care costs, utilization, salaries, technology, or other factors (2010-19).

  Cost increases based on actuarial analyses - Estimates should be used with caution, as amounts will change when additional guidance and policy decisions are made at the federal level.

  Numbers used for Blue Cross Blue Shield of North Dakota (80 plus percentage of market) assume all covered individuals remain in "grandfathered" plans throughout 2010-19. Premiums would increase as "grandfathered" status is removed.

  Numbers used for PERS and political subdivisions assume all covered employees remain in "grandfathered" plans throughout 2010-19. Premiums would increase as "grandfathered" status is removed.

  Grants and subsidies may offset some projected cost increases.

					Blue Cross/Blue Shield of North Dakota			
	Insurance Department	Department of Human Services (DHS) - Medicaid Expansion	State Department of Health	Public Employees Retirement System	Grandfathered	Non-grandfathered	Political Subdivisions	Total
2010		$725,942		Current contract	$20,200,000	$51,500,000	Current contract	$20,925,942
2011		998,634		$470,700	30,300,000	61,900,000	$151,800	31,921,134
2012	$676,018*	7,223,354		990,000	30,300,000	61,900,000	303,600	39,492,972
2013	1,429,287	9,156,319		1,029,000	30,300,000	61,900,000	314,100	42,228,706
2014	1,763,543	6,595,088		1,068,000	85,500,000	180,100,000	324,600	95,251,231
2015	1,704,116	8,408,645		1,068,000	124,900,000	223,500,000	324,600	136,405,361
2016	1,704,116	8,922,201		1,068,000	165,400,000	268,000,000	324,600	177,418,917
2017	1,704,116	18,335,757		1,068,000	165,400,000	268,000,000	324,600	186,832,473
2018	1,704,116	21,149,314		1,068,000	165,400,000	268,000,000	324,600	189,646,030
2019	1,704,116	24,462,870		1,068,000	165,400,000	268,000,000	324,600	192,959,586
Total	$12,389,428	$105,978,124		$8,897,700	$983,100,000	$1,712,800,000	$2,717,100	**$1,113,082,352**
	*Does not include information technology costs to be determined	DHS--May have other costs related to Child Support Enforcement, Behavioral Health Services, and/or delivery of services, at the human service centers		Assumes grand-fathered status 2010-19	Assumes all policies grandfathered 2010-19	Assumes all plans not grandfathered 2010-19		

	Medicare Frontier Provision	Bank of North Dakota
2010	$65,000,000	Family education loan program
2011	65,000,000	Loss of 80 percent of student loan program
2012	65,000,000	
2013	65,000,000	
2014	65,000,000	
2015	65,000,000	
2016	65,000,000	
2017	65,000,000	
2018	65,000,000	
2019	65,000,000	
Total	$650,000,000	
	Six Hospitals/physicians - Minus offset	
	Five * States qualify	
	Projected adjustments - Decreases in Medicare reimbursement ($260,000,000)	

Related Grants Applied for		
Insurance Department	**Human Services Medicaid Expansion**	**Public Employees Retirement System**
Rate review grant - $1,000,000	Nursing Home Diversion and Transition Grant - $399,000	Subsidy - Pre-Medicare retirees health insurance - $1,200,000 per year through 2013 based on funds available

2011 Legislation Enacted

House Bill No. 1125

This bill directs the Insurance Commissioner to administer and enforce the provisions of the ACA.

House Bill No. 1126

This bill directs the Insurance Commissioner and the Department of Human Services to plan for the implementation of a state American health benefit exchange that facilitates the purchase of qualified health benefit plans, provides for the establishment of a small business health options program, implements eligibility determination and enrollment of individuals in the state's medical assistance program and the state's children's health insurance program, provides simplification, provides coordination among the state's health programs, and meets the requirements of the ACA; provides deadlines for implementing the exchange; directs the Insurance Commissioner and the Department of Human Services to collaborate with the Information Technology Department; and authorizes the Insurance Commissioner and Department of Human Services to receive from and provide to federal and state agencies information gathered in the administration of the exchange as necessary.

House Bill No. 1127

This bill amends North Dakota law impacting health plans in order to implement the necessary provisions of the ACA, including limitations on risks, independent external review, external appeal procedures, and internal claims and appeals procedures.

House Bill No. 1165

This bill provides that subject to certain exclusions, regardless of whether a resident of this state has or is eligible for health insurance coverage under a health insurance policy, health service contract, or evidence of coverage by or through an employer or under a plan sponsored by the state or federal government, the resident is not required to obtain or maintain a policy of individual health coverage except as may be required by a court or by the Department of Human Services through a court or administrative proceeding.

Senate Bill No. 2037

This bill changes the membership of the Health Information Technology Advisory Committee by adding the chairman of the House Human Services Committee and the chairman of the Senate Human Services Committee or if either or both of them are unwilling or unable to serve a replacement selected by the chairman of the Legislative Management. The bill authorizes the Health Information Technology Advisory Committee to accept private contributions, gifts, and grants. The bill requires the director of the Health Information Technology Office to implement and administer a health information exchange that utilizes information infrastructure and systems in a secure and cost-effective manner to facilitate the collection, storage, and transmission of health records; adopt rules for the use of health information, use of the health information exchange, and participation in the health information exchange; and adopt rules for accessing the health information exchange to ensure appropriate and required privacy and security protections and relating to the authority of the director to suspend, eliminate, or terminate the right to participate in the health information exchange. The bill also requires the director to determine fees and charges for access and participation in the health information exchange and to consult and coordinate with the State Department of Health and the Department of Human Services to facilitate the collection of health information from health care providers and state agencies for public health purposes. The bill requires each executive branch state agency and each institution of higher education that implements, acquires, or upgrades health information technology systems, by January 1, 2015, to use health information technology systems and products that meet minimum standards adopted by the Health Information Technology Office for accessing the health information exchange. The bill provides that any individually identifiable health information submitted to, stored in, or transmitted by the health information exchange is confidential and any other information relating to patients, individuals, or individually identifiable demographic information contained in a master client index submitted to, stored in, or transmitted by the health information exchange is an exempt record. The bill provides immunity from criminal or civil liability for any health care provider that relies in good faith upon any information provided through the health information exchange in the treatment of a patient for any damages caused by that good-faith reliance. The bill provides that effective January 1, 2015, an executive branch state agency, an institution of higher education, and any health care provider or other person participating in the health information exchange may use only an electronic health record system for use in the exchange which is certified under rules adopted by the Office of the National Coordinator for Health Information Technology.

Senate Bill No. 2309

This bill provides that the ACA likely is not authorized by the United States Constitution and may violate its true meaning and intent as given by the founders and ratifiers. The bill requires the Legislative Assembly to consider enacting any measure necessary to prevent the enforcement of the ACA within this state and provides that no provision of the ACA may interfere with an individual's choice of a medical or insurance provider except as otherwise provided by the laws of this state.

POSSIBLE STUDY APPROACH

In conducting this study, it will be necessary to establish a firm timeline of required state action. In addition to working with the private sector and state agencies to determine the impact of the ACA and to determine what state actions are required and the timeline for those actions, the committee members may wish to review "The 2011 State Legislators' Check List for Health Reform Implementation" published by the National Conference of State Legislatures in February 2011. A copy of this document is attached as Appendix D.

ATTACH:4

Sixty-second Legislative Assembly of North Dakota
In Regular Session Commencing Tuesday, January 4, 2011

HOUSE BILL NO. 1252
(Representative Carlson)

AN ACT to establish a legislative management health care reform review committee.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT HEALTH CARE REFORM REVIEW COMMITTEE. During the 2011-12 interim, the chairman of the legislative management shall appoint a committee to monitor the impact of the federal Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010; rules adopted by federal agencies as a result of that legislation; and any amendments to that legislation. The membership of the committee must include the chairmen of the house human services committee and the house industry, business and labor committee and the chairmen of the senate human services committee and the senate industry, business and labor committee. If any of those individuals are unwilling or unable to serve, the chairman of the legislative management shall appoint a replacement who is a member of the same legislative chamber as the individual being replaced. If a special session of the legislative assembly is necessary to adopt legislation in response to the federal legislation, the committee shall report to the legislative management before any special session. The committee shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the legislative management, which shall report the findings and recommendations to the sixty-third legislative assembly.

FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

SUMMARY OF NEW HEALTH REFORM LAW

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law. The following summary of the law, and changes made to the law by subsequent legislation, focuses on provisions to expand coverage, control health care costs, and improve health care delivery system.

	Patient Protection and Affordable Care Act (P.L. 111-148)
Overall approach to expanding access to coverage	Require most U.S. citizens and legal residents to have health insurance. Create state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 133-400% of the federal poverty level (the poverty level is $18,310 for a family of three in 2009) and create separate Exchanges through which small businesses can purchase coverage. Require employers to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for small employers. Impose new regulations on health plans in the Exchanges and in the individual and small group markets. Expand Medicaid to 133% of the federal poverty level.
INDIVIDUAL MANDATE	
Requirement to have coverage	• Require U.S. citizens and legal residents to have qualifying health coverage. Those without coverage pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income. The penalty will be phased-in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples).
EMPLOYER REQUIREMENTS	
Requirement to offer coverage	• Assess employers with 50 or more full-time employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with 50 or more full-time employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee, excluding the first 30 employees from the assessment. (Effective January 1, 2014) • Exempt employers with up to 50 full-time employees from any of the above penalties.
Other requirements	• Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.
EXPANSION OF PUBLIC PROGRAMS	
Treatment of Medicaid	• Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (as under current law and in the House and Senate-passed bills undocumented immigrants are not eligible for Medicaid). All newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges. To finance the coverage for the newly eligible (those who were not previously eligible for at least benchmark equivalent coverage, those who were eligible for a capped program but were not enrolled, or those who were enrolled in state-funded programs), states will receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years. States that have already expanded eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for non-pregnant childless adults so that by 2019 they receive the same

	Patient Protection and Affordable Care Act (P.L. 111-148)
EXPANSION OF PUBLIC PROGRAMS (continued)	
Treatment of Medicaid (continued)	federal financing as other states (93% in 2019 and 90% in 2020 and later). States have the option to expand Medicaid eligibility to childless adults beginning on April 1, 2010, but will receive their regular FMAP until 2014. In addition, increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates. (Effective January 1, 2014)
Treatment of CHIP	• Require states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. CHIP benefit package and cost-sharing rules will continue as under current law. Provide states with the option to provide CHIP coverage to children of state employees who are eligible for health benefits if certain conditions are met. Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%. CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state Exchanges.
PREMIUM AND COST-SHARING SUBSIDIES TO INDIVIDUALS	
Eligibility	• Limit availability of premium credits and cost-sharing subsidies through the Exchanges to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee share of the premium exceeds 9.5% of income. Legal immigrants who are barred from enrolling in Medicaid during their first five years in the U.S. will be eligible for premium credits.
Premium credits	• Provide refundable and advanceable premium credits to eligible individuals and families with incomes between 133-400% FPL to purchase insurance through the Exchanges. The premium credits will be tied to the second lowest cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income levels: Up to 133% FPL: 2% of income 133-150% FPL: 3 – 4% of income 150-200% FPL: 4 – 6.3% of income 200-250% FPL: 6.3 – 8.05% of income 250-300% FPL: 8.05 – 9.5% of income 300-400% FPL: 9.5% of income • Increase the premium contributions for those receiving subsidies annually to reflect the excess of the premium growth over the rate of income growth for 2014-2018. Beginning in 2019, further adjust the premium contributions to reflect the excess of premium growth over CPI if aggregate premiums and cost sharing subsidies exceed .54% of GDP. • Provisions related to the premium and cost-sharing subsidies are effective January 1, 2014.
Cost-sharing subsidies	• Provide cost-sharing subsidies to eligible individuals and families. The cost-sharing credits reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income level: 100-150% FPL: 94% 150-200% FPL: 87% 200-250% FPL: 73% 250-400% FPL: 70%
Verification	• Require verification of both income and citizenship status in determining eligibility for the federal premium credits.
Subsidies and abortion coverage	• Ensure that federal premium or cost-sharing subsidies are not used to purchase coverage for abortion if coverage extends beyond saving the life of the woman or cases of rape or incest (Hyde amendment). If an individual who receives federal assistance purchases coverage in a plan that chooses to cover abortion services beyond those for which federal funds are permitted, those federal subsidy funds (for premiums or cost-sharing) must not be used for the purchase of the abortion coverage and must be segregated from private premium payments or state funds.

	Patient Protection and Affordable Care Act (P.L. 111-148)
PREMIUM SUBSIDIES TO EMPLOYERS	
Small business tax credits	• Provide small employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees with a tax credit. – *Phase I:* For tax years 2010 through 2013, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium. – *Phase II:* For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium.
Reinsurance program	• Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. Program will reimburse employers or insurers for 80% of retiree claims between $15,000 and $90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Appropriate $5 billion to finance the program. (Effective 90 days following enactment through January 1, 2014)
TAX CHANGES RELATED TO HEALTH INSURANCE OR FINANCING HEALTH REFORM	
Tax changes related to health insurance	• Impose a tax on individuals without qualifying coverage of the greater of $695 per year up to a maximum of three times that amount or 2.5% of household income to be phased-in beginning in 2014. • Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account. (Effective January 1, 2011) • Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% (from 10% for HSAs and from 15% for Archer MSAs) of the disbursed amount. (Effective January 1, 2011) • Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year increased annually by the cost of living adjustment. (Effective January 1, 2013) • Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016. (Effective January 1, 2013) • Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and impose a 3.8% tax on unearned income for higher-income taxpayers (thresholds are not indexed). (Effective January 1, 2013) • Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage (these threshold values will be indexed to the consumer price index for urban consumers (CPI-U) for years beginning in 2020). The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by $1,650 for individual coverage and $3,450 for family coverage. The threshold amounts may be adjusted upwards if health care costs rise more than expected prior to implementation of the tax in 2018. The threshold amounts will be increased for firms that may have higher health care costs because of the age or gender of their workers. The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for supplementary health insurance coverage, excluding dental and vision coverage. (Effective January 1, 2018) • Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments. (Effective January 1, 2013)

	Patient Protection and Affordable Care Act (P.L. 111-148)
TAX CHANGES RELATED TO HEALTH INSURANCE OR FINANCING HEALTH REFORM (continued)	
Tax changes related to financing health reform	• Impose new annual fees on the pharmaceutical manufacturing sector, according to the following schedule: – $2.8 billion in 2012-2013; – $3.0 billion in 2014-2016; – $4.0 billion in 2017; – $4.1 billion in 2018; and – $2.8 billion in 2019 and later. • Impose an annual fee on the health insurance sector, according to the following schedule: – $8 billion in 2014; – $11.3 billion in 2015-2016; – $13.9 billion in 2017; – $14.3 billion in 2018 – For subsequent years, the fee shall be the amount from the previous year increased by the rate of premium growth. For non-profit insurers, only 50% of net premiums are taken into account in calculating the fee. Exemptions granted for non-profit plans that receive more than 80% of their income from government programs targeting low-income or elderly populations, or people with disabilities, and voluntary employees' beneficiary associations (VEBAs) not established by an employer. (Effective January 1, 2014) • Impose an excise tax of 2.3% on the sale of any taxable medical device. (Effective for sales after December 31, 2012) • Limit the deductibility of executive and employee compensation to $500,000 per applicable individual for health insurance providers. (Effective January 1, 2009) • Impose a tax of 10% on the amount paid for indoor tanning services. (Effective July 1, 2010) • Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit. (Effective January 1, 2010) • Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance. (Effective upon enactment)
HEALTH INSURANCE EXCHANGES	
Creation and structure of health insurance exchanges	• Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area. (Funding available to states to establish Exchanges within one year of enactment and until January 1, 2015)
Eligibility to purchase in the exchanges	• Restrict access to coverage through the Exchanges to U.S. citizens and legal immigrants who are not incarcerated.
Public plan option	• Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law. Each multi-state plan must be licensed in each state and must meet the qualifications of a qualified health plan. If a state has lower age rating requirements than 3:1, the state may require multi-state plans to meet the more protective age rating rules. These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool.
Consumer Operated and Oriented Plan (CO-OP)	• Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia to offer qualified health plans. To be eligible to receive funds, an organization must not be an existing health insurer or sponsored by a state or local government, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. (Appropriate $4.8 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013)

	Patient Protection and Affordable Care Act (P.L. 111-148)
HEALTH INSURANCE EXCHANGES (continued)	
Benefit tiers	• Create four benefit categories of plans plus a separate catastrophic plan to be offered through the Exchange, and in the individual and small group markets: – *Bronze plan* represents minimum creditable coverage and provides the essential health benefits, cover 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010); – *Silver plan* provides the essential health benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Gold plan* provides the essential health benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Platinum plan* provides the essential health benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Catastrophic plan* available to those up to age 30 or to those who are exempt from the mandate to purchase coverage and provides catastrophic coverage only with the coverage level set at the HSA current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market. • Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels: – 100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family); – 200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family); – 300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family). These out-of-pocket reductions are applied within the actuarial limits of the plan and will not increase the actuarial value of the plan.
Insurance market and rating rules	• Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchange. • Require risk adjustment in the individual and small group markets and in the Exchange. (Effective January 1, 2014)
Qualifications of participating health plans	• Require qualified health plans participating in the Exchange to meet marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, use a uniform enrollment form and standard format to present plan information. • Require qualified health plans to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language.
Requirements of the exchanges	• Require the Exchanges to maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. Require states to develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail or by phone. Permit Exchanges to contract with state Medicaid agencies to determine eligibility for tax credits in the Exchanges. • Require Exchanges to submit financial reports to the Secretary and comply with oversight investigations including a GAO study on the operation and administration of Exchanges.
Basic health plan	• Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees. States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges.
Abortion coverage	• Permit states to prohibit plans participating in the Exchange from providing coverage for abortions. • Require plans that choose to offer coverage for abortions beyond those for which federal funds are permitted (to save the life of the woman and in cases of rape or incest) in states that allow such coverage to create allocation accounts for segregating premium payments for coverage of abortion services from premium payments for coverage for all other services to ensure that no federal premium or cost-sharing subsidies are used to pay for the abortion coverage. Plans must also estimate the actuarial value of covering abortions by taking into account the cost of the abortion benefit (valued at no

	Patient Protection and Affordable Care Act (P.L. 111-148)
HEALTH INSURANCE EXCHANGES (continued)	
Abortion coverage (continued)	less than $1 per enrollee per month) and cannot take into account any savings that might be reaped as a result of the abortions. Prohibit plans participating in the Exchanges from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.
Effective dates	• Unless otherwise noted, provisions relating to the American Health Benefit Exchanges are effective January 1, 2014.
BENEFIT DESIGN	
Essential benefits package	• Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits ($5,950/individual and $11,900/family in 2010), and is not more extensive than the typical employer plan. Require the Secretary to define and annually update the benefit package through a transparent and public process. (Effective January 1, 2014) • Require all qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, except grandfathered individual and employer-sponsored plans, to offer at least the essential health benefits package. (Effective January 1, 2014)
Abortion coverage	• Prohibit abortion coverage from being required as part of the essential health benefits package. (Effective January 1, 2014)
CHANGES TO PRIVATE INSURANCE	
Temporary high-risk pool	• Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. U.S. citizens and legal immigrants who have a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. Premiums for the pool will be established for a standard population and may vary by no more than 4 to 1 due to age; maximum cost-sharing will be limited to the current law HSA limit ($5,950/individual and $11,900/family in 2010). Appropriate $5 billion to finance the program. (Effective within 90 days of enactment until January 1, 2014)
Medical loss ratio and premium rate reviews	• Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011) • Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plan should be excluded from the Exchange based on unjustified premium increases. Provide grants to states to support efforts to review and approve premium increases. (Effective beginning plan year 2010)
Administrative simplification	• Adopt standards for financial and administrative transactions to promote administrative simplification. (Effective dates vary)
Dependent coverage	• Provide dependent coverage for children up to age 26 for all individual and group policies. (Effective six months following enactment)
Insurance market rules	• Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prohibit insurers from rescinding coverage except in cases of fraud. Prohibit pre-existing condition exclusions for children. (Effective six months following enactment) Beginning in January 2014, prohibit individual and group health plans from placing annual limits on the dollar value of coverage. Prior to January 2014, plans may only impose annual limits on coverage as determined by the Secretary. • Grandfather existing individual and group plans with respect to new benefit standards, but require these grandfathered plans to extend dependent coverage to adult children up to age 26 and prohibit rescissions of coverage. Require grandfathered group plans to eliminate lifetime limits on coverage and beginning in 2014, eliminate annual limits on coverage. Prior to 2014, grandfathered group plans may only impose annual limits as determined by the Secretary. Require grandfathered group plans to eliminate pre-existing condition exclusions for children within six months of enactment and by 2014 for adults, and eliminate waiting periods for coverage of greater than 90 days by 2014. (Effective six months following enactment, except where otherwise specified) • Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the individual market, in the Exchange, and in the small group market. (See new rating and market rules in Creation of insurance pooling mechanism.) (Effective January 1, 2014)

	Patient Protection and Affordable Care Act (P.L. 111-148)
CHANGES TO PRIVATE INSURANCE (continued)	
Insurance market rules (continued)	• Require all new policies (except stand-alone dental, vision, and long-term care insurance plans), including those offered through the Exchanges and those offered outside of the Exchanges, to comply with one of the four benefit categories. Existing individual and employer-sponsored plans do not have to meet the new benefit standards. (See description of benefit categories in Creation of insurance pooling mechanism.) (Effective January 1, 2014) • Limit deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits. This deductible limit will not affect the actuarial value of any plans. (Effective January 1, 2014) • Limit any waiting periods for coverage to 90 days. (Effective January 1, 2014) • Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals. Finance the reinsurance program through mandatory contributions by health insurers totaling $25 billion over three years. (Effective January 1, 2014 through December 2016) • Allow states the option of merging the individual and small group markets. (Effective January 1, 2014)
Consumer protections	• Establish an internet website to help residents identify health coverage options (effective July 1, 2010) and develop a standard format for presenting information on coverage options (effective 60 days following enactment). • Develop standards for insurers to use in providing information on benefits and coverage. (Standards developed within 12 months following enactment; insurer must comply with standards within 24 months following enactment)
Health care choice compacts and national plans	• Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued, except for rules pertaining to market conduct, unfair trade practices, network adequacy, and consumer protections. Compacts may only be approved if it is determined that the compact will provide coverage that is at least as comprehensive and affordable as coverage provided through the state Exchanges. (Regulations issued by July 1, 2013, compacts may not take effect before January 1, 2016)
Health insurance administration	• Establish the Health Insurance Reform Implementation Fund within the Department of Health and Human Services and allocate $1 billion to implement health reform policies.
STATE ROLE	
State role	• Create an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange for individuals and small businesses and provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, premium taxes, and to define rating areas. • Enroll newly eligible Medicaid beneficiaries into the Medicaid program no later than January 2014 (states have the option to expand enrollment beginning in 2011), coordinate enrollment with the new Exchanges, and implement other specified changes to the Medicaid program. Maintain current Medicaid and CHIP eligibility levels for children until 2019 and maintain current Medicaid eligibility levels for adults until the Exchange is fully operational. A state will be exempt from the maintenance of effort requirement for non-disabled adults with incomes above 133% FPL for any year from January 2011 through December 31, 2013 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year. • Establish an office of health insurance consumer assistance or an ombudsman program to serve as an advocate for people with private coverage in the individual and small group markets. (Federal grants available beginning fiscal year 2010) • Permit states to create a Basic Health Plan for uninsured individuals with incomes between 133% and 200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the Exchanges. (Effective January 1, 2014) Permit states to obtain a five-year waiver of certain new health insurance requirements if the state can demonstrate that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an Exchange plan and that the state plan does not increase the federal budget deficit. (Effective January 1, 2017)

	Patient Protection and Affordable Care Act (P.L. 111-148)
COST CONTAINMENT	
Administrative simplification	• Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life. (Effective April 1, 2014)
Medicare	• Restructure payments to Medicare Advantage (MA) plans by setting payments to different percentages of Medicare fee-for-service (FFS) rates, with higher payments for areas with low FFS rates and lower payments (95% of FFS) for areas with high FFS rates. Phase-in revised payments over 3 years beginning in 2011, for plans in most areas, with payments phased-in over longer periods (4 years and 6 years) for plans in other areas. Provide bonuses to plans receiving 4 or more stars, based on the current 5-star quality rating system for Medicare Advantage plans, beginning in 2012; qualifying plans in qualifying areas receive double bonuses. Modify rebate system with rebates allocated based on a plan's quality rating. Phase-in adjustments to plan payments for coding practices related to the health status of enrollees, with adjustments equaling 5.7% by 2019. Cap total payments, including bonuses, at current payment levels. Require Medicare Advantage plans to remit partial payments to the Secretary if the plan has a medical loss ratio of less than 85%, beginning 2014. Require the Secretary to suspend plan enrollment for 3 years if the medical loss ratio is less than 85% for 2 consecutive years and to terminate the plan contract if the medical loss ratio is less than 85% for 5 consecutive years. • Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity. (Effective dates vary) • Freeze the threshold for income-related Medicare Part B premiums for 2011 through 2019, and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple. (Effective January 1, 2011) • Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning April 2013, require the Chief Actuary of CMS to project whether Medicare per capita spending exceeds the average of CPI-U and CPI-M, based on a five year period ending that year. If so, beginning January 15, 2014, the Board will submit recommendations to achieve reductions in Medicare spending. Beginning January 2018, the target is modified such that the board submits recommendations if Medicare per capita spending exceeds GDP per capita plus one percent. The Board will submit proposals to the President and Congress for immediate consideration. The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D. Hospitals and hospices (through 2019) and clinical labs (for one year) will not be subject to cost reductions proposed by the Board. The Board must also submit recommendations every other year to slow the growth in national health expenditures while preserving quality of care by January 1, 2015. • Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided (Effective fiscal year 2014) • Eliminate the Medicare Improvement Fund. (Effective upon enactment) • Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012) • Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care. Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs. (Effective January 1, 2011) • Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions. (Effective October 1, 2012) • Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)

	Patient Protection and Affordable Care Act (P.L. 111-148)
COST CONTAINMENT (continued)	
Medicaid	• Increase the Medicaid drug rebate percentage for brand name drugs to 23.1 (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price. (Effective January 1, 2010) Extend the drug rebate to Medicaid managed care plans. (Effective upon enactment) • Reduce aggregate Medicaid DSH allotments by $.5 billion in 2014, $.6 billion in 2015, $.6 billion in 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019, and $4 billion in 2020. Require the Secretary to develop a methodology to distribute the DSH reductions in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured or those that do not target DSH payments, imposes smaller reductions for low-DSH states, and accounts for DSH allotments used for 1115 waivers. (Effective October 1, 2011) • Prohibit federal payments to states for Medicaid services related to health care acquired conditions. (Effective July 1, 2011)
Prescription drugs	• Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. (Effective upon enactment)
Waste, fraud, and abuse	• Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, including a 90-day period of enhanced oversight for initial claims of DME suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develop a database to capture and share data across federal and state programs, increase penalties for submitting false claims, strengthen standards for community mental health centers and increase funding for anti-fraud activities. (Effective dates vary)
IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE	
Comparative effectiveness research	• Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage. (Funding available beginning fiscal year 2010) Terminate the Federal Coordinating Council for Comparative Effectiveness Research that was founded under the American Recovery and Reinvestment Act. (Effective upon enactment)
Medical malpractice	• Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Preference will be given to states that have developed alternatives in consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance. (Funding appropriated for five years beginning in fiscal year 2011)
Medicare	• Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, develop a plan for expanding the pilot program. (Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016) • Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. (Effective January 1, 2012) • Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010. (Effective October 1, 2012) Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers. (Reports to Congress due January 1, 2011)
Dual eligibles	• Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to more effectively integrate Medicare and Medicaid benefits and improve coordination between the federal government and states in order to improve access to and quality of care and services for dual eligibles. (Effective March 1, 2010)

	Patient Protection and Affordable Care Act (P.L. 111-148)
IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE (continued)	
Medicaid	• Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for home health-related services, including care management, care coordination, and health promotion. (Effective January 1, 2011) • Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015). • Expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid). ($11 million in additional funds appropriated for fiscal year 2010)
Primary care	• Increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates. (Effective January 1, 2013) • Provide a 10% bonus payment to primary care physicians in Medicare from 2011 through 2015. (Effective for five years beginning January 1, 2011)
National quality strategy	• Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. (National strategy due to Congress by January 1, 2011) • Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning in FY 2011)
Financial disclosure	• Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. (Report due to Congress April 1, 2013)
Disparities	• Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Also require collection of access and treatment data for people with disabilities. Require the Secretary to analyze the data to monitor trends in disparities. (Effective two years following enactment)
PREVENTION/WELLNESS	
National strategy	• Establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities. Develop a national strategy to improve the nation's health. (Strategy due one year following enactment) Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. (Initial appropriation in fiscal year 2010) Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (Effective upon enactment) • Establish a Prevention and Public Health Fund for prevention, wellness, and public health activities including prevention research and health screenings, the Education and Outreach Campaign for preventive benefits, and immunization programs. Appropriate $7 billion in funding for fiscal years 2010 through 2015 and $2 billion for each fiscal year after 2015. (Effective fiscal year 2010) • Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. (Funds appropriated for five years beginning in FY 2010)
Coverage of preventive services	• Eliminate cost-sharing for Medicare covered preventive services that are recommended (rated A or B) by the U.S. Preventive Services Task Force and waive the Medicare deductible for colorectal cancer screening tests. Authorize the Secretary to modify or eliminate Medicare coverage of preventive services, based on recommendations of the U.S. Preventive Services Task Force. (Effective January 1, 2011)

	Patient Protection and Affordable Care Act (P.L. 111-148)
PREVENTION/WELLNESS (continued)	
Coverage of preventive services (continued)	• Provide states that offer Medicaid coverage of and remove cost-sharing for preventive services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations with a one percentage point increase in the federal medical assistance percentage (FMAP) for these services. (Effective January 1, 2013) • Authorize Medicare coverage of personalized prevention plan services, including a comprehensive health risk assessment, annually. Require the Secretary to publish guidelines for the health risk assessment no later than March 23, 2011, and a health risk assessment model by no later than September 29, 2011. Reimburse providers 100% of the physician fee schedule amount with no adjustment for deductible or coinsurance for personalized prevention plan services when these services are provided in an outpatient setting. (Effective January 1, 2011) • Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. (Effective January 1, 2011 or when program criteria is developed, whichever is first) Require Medicaid coverage for tobacco cessation services for pregnant women. (Effective October 1, 2010) • Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. (Effective six months following enactment)
Wellness programs	• Provide grants for up to five years to small employers that establish wellness programs. (Funds appropriated for five years beginning in fiscal year 2011) • Provide technical assistance and other resources to evaluate employer-based wellness programs. Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. (Conduct study within two years following enactment) • Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (Effective January 1, 2014) Establish 10-state pilot programs by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market and expand demonstrations in 2017 if effective. Require a report on the effectiveness and impact of wellness programs. (Report due three years following enactment)
Nutritional information	• Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)
LONG-TERM CARE	
CLASS Act	• Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. (Effective January 1, 2011)
Medicaid	• Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016 (effective 30 days following enactment) and allocate $10 million per year for five years to continue the Aging and Disability Resource Center initiatives (funds appropriated for fiscal years 2010 through 2014). • Provide states with new options for offering home and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and who have a higher level of need and permit states to extend full Medicaid benefits to individual receiving home and community-based services under a state plan. (Effective October 1, 2010) • Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. (Effective October 1, 2011) • Create the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally-based long-term services and supports. (Effective October 1, 2011 through September 30, 2015)

	Patient Protection and Affordable Care Act (P.L. 111-148)
LONG-TERM CARE (continued	
Skilled nursing facility requirements	• Require skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures. Publish standardized information on nursing facilities to a website so Medicare enrollees can compare the facilities. (Effective dates vary)
OTHER INVESTMENTS	
Medicare	• Make improvements to the Medicare program: – Provide a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 (Effective January 1, 2010); – Phase down gradually the beneficiary coinsurance rate in the Medicare Part D coverage gap from 100% to 25% by 2020: • For brand-name drugs, require pharmaceutical manufacturers to provide a 50% discount on prescriptions filled in the Medicare Part D coverage gap beginning in 2011, in addition to federal subsidies of 25% of the brand-name drug cost by 2020 (phased in beginning in 2013) • For generic drugs, provide federal subsidies of 75% of the generic drug cost by 2020 for prescriptions filled in the Medicare Part D coverage gap (phased in beginning in 2011); Between 2014 and 2019, reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage; – Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care (Effective no earlier than January 1, 2012); – Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result (Effective upon enactment); – Provide a 10% bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas, from 2011 through 2015; and – Provide payments totaling $400 million in fiscal years 2011 and 2012 to qualifying hospitals in counties with the lowest quartile Medicare spending; and – Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program. (Effective January 1, 2011)
Workforce	• Improve workforce training and development: – Establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy. (Appointments made by September 30, 2010) – Increase the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios (effective July 1, 2011); increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings (effective July 1, 2010); and ensure the availability of residency programs in rural and underserved areas. Establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers that are eligible for payments for the expenses associated with operating primary care residency programs. (Funds appropriated for five years beginning fiscal year 2011) – Increase workforce supply and support training of health professionals through scholarships and loans; support primary care training and capacity building; provide state grants to providers in medically underserved areas; train and recruit providers to serve in rural areas; establish a public health workforce loan repayment program; provide medical residents with training in preventive medicine and public health; promote training of a diverse workforce; and promote cultural competence training of health care professionals. (Effective dates vary) Support the development of interdisciplinary mental and behavioral health training programs (effective fiscal year 2010) and establish a training program for oral health professionals. (Funds appropriated for six years beginning in fiscal year 2010) – Address the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. (Initial appropriation in fiscal year 2010) Provide grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics. (Funds appropriated for five years beginning in fiscal year 2011)

	Patient Protection and Affordable Care Act (P.L. 111-148)
OTHER INVESTMENTS (continued)	
Workforce (continued)	– Support the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services. (Funds appropriated for five years beginning in fiscal year 2010)
Community health centers and school-based health centers	• Improve access to care by increasing funding by $11 billion for community health centers and by $1.5 billion for National Health Service Corps over five years (effective fiscal year 2011); establishing new programs to support school-based health centers (effective fiscal year 2010) and nurse-managed health clinics (effective fiscal year 2010).
Trauma care	• Establish a new trauma center program to strengthen emergency department and trauma center capacity. Fund research on emergency medicine, including pediatric emergency medical research, and develop demonstration programs to design, implement, and evaluate innovative models for emergency care systems. (Funds appropriated beginning in fiscal year 2011)
Public health and disaster preparedness	• Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency. (Funds appropriated for five years beginning in fiscal year 2010)
Requirements for non-profit hospitals	• Impose additional requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions. Impose a tax of $50,000 per year for failure to meet these requirements. (Effective for taxable years following enactment)
American Indians	• Reauthorize and amend the Indian Health Care Improvement Act. (Effective upon enactment)
FINANCING	
Coverage and financing	The Congressional Budget Office (CBO) estimates the new health reform law will provide coverage to an additional 32 million when fully implemented in 2019 through a combination of the newly created Exchanges and the Medicaid expansion. CBO estimates the cost of the coverage components of the new law to be $938 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees, including an excise tax on high-cost insurance, which CBO estimates will raise $32 billion over ten years. CBO also estimates that the health reform law will reduce the deficit by $124 billion over ten years.

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THE HENRY J. KAISER FAMILY FOUNDATION www.kff.org

Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800
Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274

HealthCare.gov

About the Law

Provisions of the Affordable Care Act, By Year

2010 2011 2012 2013 2014 2015

2010

NEW CONSUMER PROTECTIONS

- **Putting Information for Consumers Online.** The law provides for an easy-to-use website where consumers can compare health insurance coverage options and pick the coverage that works for them. *Effective July 1, 2010.*
- **Prohibiting Denying Coverage of Children Based on Pre-Existing Conditions.** The new law includes new rules to prevent insurance companies from denying coverage to children under the age of 19 due to a pre-existing condition. *Effective for health plan years beginning on or after September 23, 2010 for new plans and existing group plans.*
- **Prohibiting Insurance Companies from Rescinding Coverage.** In the past, insurance companies could search for an error, or other technical mistake, on a customer's application and use this error to deny payment for services when he or she got sick. The new law makes this illegal. After media reports cited incidents of breast cancer patients losing coverage, insurance companies agreed to end this practice immediately. *Effective for health plan years beginning on or after September 23, 2010.*
- **Eliminating Lifetime Limits on Insurance Coverage.** Under the new law, insurance companies will be prohibited from imposing lifetime dollar limits on essential benefits, like hospital stays. *Effective for health plan years beginning on or after September 23, 2010.*
- **Regulating Annual Limits on Insurance Coverage.** Under the new law, insurance companies' use of annual dollar limits on the amount of insurance coverage a patient may receive will be restricted for new plans in the individual market and all group plans. In 2014, the use of annual dollar limits on essential benefits like hospital stays will be banned for new plans in the individual market and all group plans. *Effective for health plan years beginning on or after September 23, 2010.*
- **Appealing Insurance Company Decisions.** The law provides consumers with a way to appeal coverage determinations or claims to their insurance company, and establishes an external review process. *Effective for new plans beginning on or after September 23, 2010.*
- **Establishing Consumer Assistance Programs in the States.** Under the new law, states that apply receive federal grants to help set up or expand independent offices to help consumers navigate the private health insurance system. These programs help consumers file complaints and appeals; enroll in health coverage; and get educated about their rights and responsibilities in group health plans or individual health insurance policies. The programs will also collect data on the types of problems consumers have, and file reports with the U.S. Department of Health and Human Services to identify trouble spots that need further oversight. *Grants Awarded October 2010.* Learn more about Consumer Assistance Programs.

IMPROVING QUALITY AND LOWERING COSTS

- **Providing Small Business Health Insurance Tax Credits.** Up to 4 million small businesses are

eligible for tax credits to help them provide insurance benefits to their workers. The first phase of this provision provides a credit worth up to 35 percent of the employer's contribution to the employees' health insurance. Small non-profit organizations may receive up to a 25 percent credit. *Effective now.*

- **Offering Relief for 4 Million Seniors Who Hit the Medicare Prescription Drug "Donut Hole."** An estimated four million seniors will reach the gap in Medicare prescription drug coverage known as the "donut hole" this year. Each eligible senior will receive a one-time, tax free $250 rebate check. *First checks mailed in June, 2010, and will continue monthly throughout 2010 as seniors hit the coverage gap.* Learn more about the "donut hole" and Medicare.
- **Providing Free Preventive Care.** All new plans must cover certain preventive services such as mammograms and colonoscopies without charging a deductible, co-pay or coinsurance. *Effective for health plan years beginning on or after September 23, 2010.* Learn more about preventive care benefits.
- **Preventing Disease and Illness.** A new $15 billion Prevention and Public Health Fund will invest in proven prevention and public health programs that can help keep Americans healthy – from smoking cessation to combating obesity. *Funding begins in 2010.* See prevention funding and grants in your state.
- **Cracking Down on Health Care Fraud.** Current efforts to fight fraud have returned more than $2.5 billion to the Medicare Trust Fund in fiscal year 2009 alone. The new law invests new resources and requires new screening procedures for health care providers to boost these efforts and reduce fraud and waste in Medicare, Medicaid, and CHIP. *Many provisions effective now.* Fact Sheet: New Tools to Fight Fraud

INCREASING ACCESS TO AFFORDABLE CARE

- **Providing Access to Insurance for Uninsured Americans with Pre-Existing Conditions.** A new Pre-Existing Condition Insurance Plan will provide new coverage options to individuals who have been uninsured for at least six months because of a pre-existing condition. States have the option of running this new program in their state. If a state chooses not to do so, a plan will be established by the Department of Health and Human Services in that state. *National program effective July 1, 2010.*
- ***Extending Coverage for Young Adults.*** Under the new law, young adults will be allowed to stay on their parents' plan until they turn 26 years old (in the case of existing group health plans, this right does not apply if the young adult is offered insurance at work). While the provision takes effect in September, many insurance companies have already implemented this new practice. Check with your insurance company or employer to see if you qualify. *Effective for health plan years beginning on or after September 23.*
- **Expanding Coverage for Early Retirees.** Too often, Americans who retire without employer-sponsored insurance and before they are eligible for Medicare see their life savings disappear because of high rates in the individual market. To preserve employer coverage for early retirees until more affordable coverage is available through the new Exchanges by 2014, the new law creates a $5 billion program to provide needed financial help for employment-based plans to continue to provide valuable coverage to people who retire between the ages of 55 and 65, as well as their spouses and dependents. *Applications for employers to participate in the program available June 1, 2010.* For more information on the Early Retiree Reinsurance Program, visit www.ERRP.gov.
- **Rebuilding the Primary Care Workforce.** To strengthen the availability of primary care, there are new incentives in the law to expand the number of primary care doctors, nurses and physician assistants. These include funding for scholarships and loan repayments for primary care doctors and nurses working in underserved areas. Doctors and nurses receiving payments made under any State loan repayment or loan forgiveness program intended to increase the availability of health care services in underserved or health professional shortage areas will not have to pay taxes on those payments. *Effective 2010* .
- **Holding Insurance Companies Accountable for Unreasonable Rate Hikes**. The law allows states

that have, or plan to implement, measures that require insurance companies to justify their premium increases will be eligible for $250 million in new grants. Insurance companies with excessive or unjustified premium exchanges may not be able to participate in the new health insurance Exchanges in 2014. *Grants awarded beginning in 2010.*

- **Allowing States to Cover More People on Medicaid.** States will be able to receive federal matching funds for covering some additional low-income individuals and families under Medicaid for whom federal funds were not previously available. This will make it easier for states that choose to do so to cover more of their residents. *Effective April 1, 2010.* Learn more about Medicaid.
- **Increasing Payments for Rural Health Care Providers.** Today, 68 percent of medically underserved communities across the nation are in rural areas. These communities often have trouble attracting and retaining medical professionals. The law provides increased payment to rural health care providers to help them continue to serve their communities. *Effective 2010.*
- **Strengthening Community Health Centers.** The law includes new funding to support the construction of and expand services at community health centers, allowing these centers to serve some 20 million new patients across the country. *Effective 2010.* Learn more about Rural Americans and the Affordable Care Act.

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2011

IMPROVING QUALITY AND LOWERING COSTS

- **Offering Prescription Drug Discounts.** Seniors who reach the coverage gap will receive a 50 percent discount when buying Medicare Part D covered brand-name prescription drugs. Over the next ten years, seniors will receive additional savings on brand-name and generic drugs until the coverage gap is closed in 2020. *Effective January 1, 2011.* Download a brochure to learn more (PDF - 3.6 MB)
- **Providing Free Preventive Care for Seniors.** The law provides certain free preventive services, such as annual wellness visits and personalized prevention plans for seniors on Medicare. *Effective January 1, 2011.* Learn more about preventive services under Medicare.
- **Improving Health Care Quality and Efficiency.** The law establishes a new Center for Medicare & Medicaid Innovation that will begin testing new ways of delivering care to patients. These methods are expected to improve the quality of care, and reduce the rate of growth in health care costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Additionally, by January 1, 2011, HHS will submit a national strategy for quality improvement in health care, including by these programs. *Effective no later than January 1, 2011.* Learn more about the Center for Medicare & Medicaid Innovation.
- **Improving Care for Seniors After They Leave the Hospital.** The Community Care Transitions Program will help high risk Medicare beneficiaries who are hospitalized avoid unnecessary readmissions by coordinating care and connecting patients to services in their communities. *Effective January 1, 2011.*
- **Introducing New Innovations to Bring Down Costs.** The Independent Payment Advisory Board will begin operations to develop and submit proposals to Congress and the President aimed at extending the life of the Medicare Trust Fund. The Board is expected to focus on ways to target waste in the system, and recommend ways to reduce costs, improve health outcomes for patients, and expand access to high-quality care. *Administrative funding becomes available October 1, 2011.* Learn more about strengthening Medicare.

INCREASING ACCESS TO AFFORDABLE CARE

- **Increasing Access to Services at Home and in the Community.** The new Community First Choice Option allows States to offer home and community based services to disabled individuals through

Medicaid rather than institutional care in nursing homes. *Effective beginning October 1, 2011.*

HOLDING INSURANCE COMPANIES ACCOUNTABLE

- **Bringing Down Health Care Premiums.** To ensure premium dollars are spent primarily on health care, the new law generally requires that at least 85% of all premium dollars collected by insurance companies for large employer plans are spent on health care services and health care quality improvement. For plans sold to individuals and small employers, at least 80% of the premium must be spent on benefits and quality improvement. If insurance companies do not meet these goals, because their administrative costs or profits are too high, they must provide rebates to consumers. *Effective January 1, 2011.* Fact Sheet: Getting Value for Your Health Care Dollars
- **Addressing Overpayments to Big Insurance Companies and Strengthening Medicare Advantage.** Today, Medicare pays Medicare Advantage insurance companies over $1,000 more per person on average than is spent per person in Traditional Medicare. This results in increased premiums for all Medicare beneficiaries, including the 77 percent of beneficiaries who are not currently enrolled in a Medicare Advantage plan. The new law levels the playing field by gradually eliminating this discrepancy. People enrolled in a Medicare Advantage plan will still receive all guaranteed Medicare benefits, and the law provides bonus payments to Medicare Advantage plans that provide high quality care. *Effective January 1, 2011. Download a brochure to learn more (PDF - 316 KB)*

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IMPROVING QUALITY AND LOWERING COSTS

- **Linking Payment to Quality Outcomes.** The law establishes a hospital Value-Based Purchasing program (VBP) in Traditional Medicare. This program offers financial incentives to hospitals to improve the quality of care. Hospital performance is required to be publicly reported, beginning with measures relating to heart attacks, heart failure, pneumonia, surgical care, health-care associated infections, and patients' perception of care. *Effective for payments for discharges occurring on or after October 1, 2012.*
- **Encouraging Integrated Health Systems.** The new law provides incentives for physicians to join together to form "Accountable Care Organizations." These groups allow doctors to better coordinate patient care and improve the quality, help prevent disease and illness and reduce unnecessary hospital admissions. If Accountable Care Organizations provide high quality care and reduce costs to the health care system, they can keep some of the money that they have helped save. *Effective January 1, 2012.* Fact Sheet: Improving Care Coordination for People with Medicare.
- **Reducing Paperwork and Administrative Costs.** Health care remains one of the few industries that relies on paper records. The new law will institute a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information. Using electronic health records will reduce paperwork and administrative burdens, cut costs, reduce medical errors and most importantly, improve the quality of care. *First regulation effective October 1, 2012.* Learn how the law improves the health care system for providers, professionals, and patients.
- **Understanding and Fighting Health Disparities.** To help understand and reduce persistent health disparities, the law requires any ongoing or new Federal health program to collect and report racial, ethnic and language data. The Secretary of Health and Human Services will use this data to help identify and reduce disparities. *Effective March 2012.*

INCREASING ACCESS TO AFFORDABLE CARE

- **Providing New, Voluntary Options for Long-Term Care Insurance.** The law creates a voluntary long-term care insurance program – called CLASS -- to provide cash benefits to adults who become disabled. *The Secretary shall designate a benefit plan no later than October 1, 2012.* Learn more about the CLASS program.

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IMPROVING QUALITY AND LOWERING COSTS

- ***Improving Preventive Health Coverage.*** To expand the number of Americans receiving preventive care, the law provides new funding to state Medicaid programs that choose to cover preventive services for patients at little or no cost. *Effective January 1, 2013.* Learn more about the law and preventive care.
- **Expanding Authority to Bundle Payments.** The law establishes a national pilot program to encourage hospitals, doctors, and other providers to work together to improve the coordination and quality of patient care. Under payment "bundling," hospitals, doctors, and providers are paid a flat rate for an episode of care rather than the current fragmented system where each service or test or bundles of items or services are billed separately to Medicare. For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a "bundled" payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality of care. It aligns the incentives of those delivering care, and savings are shared between providers and the Medicare program. *Effective no later than January 1, 2013.*

INCREASING ACCESS TO AFFORDABLE CARE

- **Increasing Medicaid Payments for Primary Care Doctors.** As Medicaid programs and providers prepare to cover more patients in 2014, the Act requires states to pay primary care physicians no less than 100 percent of Medicare payment rates in 2013 and 2014 for primary care services. The increase is fully funded by the federal government. *Effective January 1, 2013.* Learn how the law supports and strengthens primary care providers.
- **Providing Additional Funding for the Children's Health Insurance Program.** Under the new law, states will receive two more years of funding to continue coverage for children not eligible for Medicaid. *Effective October 1, 2013.* Learn more about CHIP.

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2014

NEW CONSUMER PROTECTIONS

- **Prohibiting Discrimination Due to Pre-Existing Conditions or Gender.** The law implements strong reforms that prohibit insurance companies from refusing to sell coverage or renew policies because of an individual's pre-existing conditions. Also, in the individual and small group market, the law eliminates the ability of insurance companies to charge higher rates due to gender or health status. *Effective January 1, 2014.* Learn more about protecting Americans with pre-existing conditions.
- **Eliminating Annual Limits on Insurance Coverage**. The law prohibits new plans and existing group plans from imposing annual dollar limits on the amount of coverage an individual may receive. *Effective January 1, 2014.* Learn how the law will phase out annual limits by 2014.
- **Ensuring Coverage for Individuals Participating in Clinical Trials.** Insurers will be prohibited from dropping or limiting coverage because an individual chooses to participate in a clinical trial. Applies to

all clinical trials that treat cancer or other life-threatening diseases. *Effective January 1, 2014.*

IMPROVING QUALITY AND LOWERING COSTS

- **Making Care More Affordable.** Tax credits to make it easier for the middle class to afford insurance will become available for people with income between 100 percent and 400 percent of the poverty line who are not eligible for other affordable coverage. (In 2010, 400 percent of the poverty line comes out to about $43,000 for an individual or $88,000 for a family of four.) The tax credit is advanceable, so it can lower your premium payments each month, rather than making you wait for tax time. It's also refundable, so even moderate-income families can receive the full benefit of the credit. These individuals may also qualify for reduced cost-sharing (copayments, co-insurance, and deductibles). *Effective January 1, 2014.* Learn how the law will make care more affordable in 2014.
- **Establishing Health Insurance Exchanges.** Starting in 2014 if your employer doesn't offer insurance, you will be able to buy insurance directly in an Exchange -- a new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Exchanges will offer you a choice of health plans that meet certain benefits and cost standards. Starting in 2014, Members of Congress will be getting their health care insurance through Exchanges, and you will be able buy your insurance through Exchanges too. *Effective January 1, 2014.* Learn more about Exchanges.
- **Increasing the Small Business Tax Credit.** The law implements the second phase of the small business tax credit for qualified small businesses and small non-profit organizations. In this phase, the credit is up to 50 percent of the employer's contribution to provide health insurance for employees. There is also up to a 35 percent credit for small non-profit organizations. *Effective January 1, 2014.* Learn more about the small business tax credit.

INCREASING ACCESS TO AFFORDABLE CARE

- **Increasing Access to Medicaid.** Americans who earn less than 133 percent of the poverty level (approximately $14,000 for an individual and $29,000 for a family of four) will be eligible to enroll in Medicaid. States will receive 100 percent federal funding for the first three years to support this expanded coverage, phasing to 90 percent federal funding in subsequent years. *Effective January 1, 2014.* Learn more about Medicaid.
- **Promoting Individual Responsibility.** Under the new law, most individuals who can afford it will be required to obtain basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans. If affordable coverage is not available to an individual, he or she will be eligible for an exemption. *Effective January 1, 2014.* Learn more about individual responsibility and the law.
- **Ensuring Free Choice.** Workers meeting certain requirements who cannot afford the coverage provided by their employer may take whatever funds their employer might have contributed to their insurance and use these resources to help purchase a more affordable plan in the new health insurance Exchanges. *Effective January 1, 2014.* Learn more about coming improvements for small employers.

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IMPROVING QUALITY AND LOWERING COSTS

- **Paying Physicians Based on Value Not Volume.** A new provision will tie physician payments to the quality of care they provide. Physicians will see their payments modified so that those who provide higher value care will receive higher payments than those who provide lower quality care. *Effective January 1, 2015.*

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HHS will not enforce these rules against issuers of stand-alone retiree-only plans in the private health insurance market.

The 2011 State Legislators' Check List for Health Reform Implementation

FEBRUARY 2011

Rachel Morgan RN, BSN, Health Committee Director

National Conference of State Legislatures 444 North Capitol Street, N.W., Suite 515 Washington, D.C. 20001

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FY 2011 TASKS

American Health Benefits Exchanges

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**FY2011 Actions**	**ISSUE**

PLANNING FOR STATE EXCHANGE IMPLEMENTATION IN FY2014

The Affordable Care Act (ACA) establishes a plan to facilitate the purchase and sale of qualified health coverage in the individual market, and to provide options for small business through American Health Benefit Exchanges. The ACA directs states to establish and implement the operation of an exchange no later than January 1, 2014. State-established government or nonprofit entities will certifying plans and identify individuals eligible for Medicaid, CHIP, and premium and cost-sharing credits. States have several options to structure their exchanges and many of these decisions will be either made by state legislators or dependent upon actions they take in session from 2011 through to 2014.

INITIAL GUIDANCE TO STATES ON EXCHANGES

The Department of Health and Human Services released guidance November 18th to assist states in the development of their exchanges. The secretary plans to release regulations for public comment in 2011, but has provided this guidance to assist states and territories with their overall planning, including the legislative plans for 2011. This guidance is the first in a series of documents that will be released by HHS over the next three years. The categories of information in this document cover the following:

- Principles and Priorities
- Outline of Statutory Requirements
- Clarifications and Policy Guidance, and
- Federal Support for the Establishment of State based exchanges.

The exchanges have been defined as a mechanism for organizing the health insurance marketplace to help consumers and small business shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality.

LINK TO INITIAL GUIDANCE DOCUMENT— http://www.ncsl.org/documents/health/1118ExchGuid.pdf

FY 2011 TASKS				
AMERICAN HEALTH BENEFITS EXCHANGES				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**FY2011 Actions**	**PLANNING FOR STATE EXCHANGE IMPLEMENTATION IN FY2014** *(continued)* **LEGISLATIVE CONSIDERATIONS [Based on recommendations from the NAIC model act]** ▪ State options for consideration relating to exchange structure: 1. Designation of the oversight authority within: ▪ a new or existing state agency, or ▪ an independent public agency, or quasi-governmental agency, 2. Whether to establish a regional or interstate exchange, and 3. Whether to operate a unified exchange by merging the SHOP Exchange[1] and the exchange for the individual market. ▪ Determine governance mechanisms if the exchange is not located within a state agency including: 1. a governing board, it's size, composition and terms, 2. determine the process of appointments to the board, their powers and duties, 3. designation of committees or other entities involved in day-to-day responsibilities, and 4. licensure requirements. ▪ If the state exchange will require certain health benefits that exceed the essential benefits package established by the Department of Health and Human Services. *(States must develop a mechanism to defray the cost of additional benefits in relation to premium and cost-sharing assistance for enrollees.)* ▪ Duties of the exchange. ▪ Designate state authority responsible for health benefit plan certification. ▪ Conform all state law to Federal ERISA fiduciary duties. ▪ Grant necessary rule making authority to appropriate state entities responsible for implementing state law related to exchanges. ▪ Determine budget for exchange, Medicaid, and CHIP information technology systems needs capable of meeting interoperability requirement, (refer to resource documents, **Guidance for Exchange and Medicaid IT Systems, Version 1.00).**

[1] "SHOP Exchange" is defined as meaning the Small Business Health Options Program.

FY 2011 TASKS				
AMERICAN HEALTH BENEFITS EXCHANGES				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**FY2011 Actions**	**GUIDANCE FOR STATUTORY REQUIREMENT** (BASED ON HHS GUIDANCE RELEASED NOVEMBER 17, 2010) According to the ACA there are two basic types of federal requirements for exchanges which include 1) minimum functions exchanges must undertake directly or, in some cases, by contract; and 2) oversight responsibilities the exchanges must exercise in certifying and monitoring the performance of Qualified Health Plans (QHPs). Plans participating in the exchanges must also comply with state insurance laws ad federal requirements in the Public Health Service Act. **I. EXCHANGE FUNCTIONS** ▪ **Core functions that an exchange must meet:** 1. Certification, recertification and decertification of plans, 2. Operation of a toll-free hotline, 3. Maintenance of a website for providing information on plans to current and prospective enrollees, 4. Assignment of a price and quality rating to plans, 5. Presentation of plan benefit options in a standardized format, 6. Provision of information on Medicaid and CHIP eligibility and determination of eligibility for individuals in these programs, 7. Provision of an electronic calculator to determine the actual cost of coverage taking into account eligibility for premium tax credits and cost sharing reductions, 8. Certification of individuals exempt from the individual responsibility requirement, 9. Provision of information on certain individuals and to employers, 10. Establishment of a Navigator program that provides grants to entities assisting consumers. ▪ **Additional Exchange functions include:** 1. Presentation of enrollee satisfaction survey results, 2. Provision for open enrollment periods, 3. Consultation with stakeholders, including tribes, and **4.** Publication of data on the exchange's administrative costs.

FY 2011 TASKS				
AMERICAN HEALTH BENEFITS EXCHANGES				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**FY2011 Actions**	**GUIDANCE FOR STATUTORY REQUIREMENT** (BASED ON HHS GUIDANCE RELEASED NOVEMBER 17, 2010) (CONTINUED) **I. OVERSIGHT RESPONSIBILITIES** ▪ HHS is required to develop regulatory standards in five areas that insurers must meet in order to be certified as QHP by an Exchange: 1. Marketing 2. Network adequacy 3. Accreditation for performance measures 4. Quality improvement and reporting 5. Uniform enrollment procedures ▪ Additional areas where exchanges must ensure plan compliance with regulatory standards established by HHS include: 1. Information on the availability of in-network and out-of-network providers, including provider directories and availability of essential community providers, 2. Consideration of plan patterns and practices with respect to past premium increases and a submission of the plan justifications for current premium increases, 3. Public disclosure of plan data identified, including claims handling policies, financial disclosures, enrollment and disenrollment data, claims denials, rating practices, cost sharing for out of network coverage, and other information identified by HHS, 4. Timely information for consumers requesting their amount of cost sharing for specific services from specified providers, 5. Information for participants in group health plans, 6. Information on plan quality improvement activities.

FY 2011 TASKS				
AMERICAN HEALTH BENEFITS EXCHANGES				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	FY2011 Actions	CLARIFICATION AND POLICY GUIDANCE (BASED ON HHS GUIDANCE RELEASED NOVEMBER 17, 2010) (CONTINUED)

States should consider the following issues in establishing an Exchange.

- **Organizational Form**. States have the option to establish their exchange as a governmental agency or nonprofit entity. Within the governmental agency category, the exchange could be housed within an existing state office, or it could be an independent public authority. Regardless of its organizational form, the exchange must be publicly accountable, transparent, and have technically competent leadership, with the capacity and authority to meet federal standards, including the discretion to determine whether health plans offered through the exchange are "in the interests of qualified individuals and qualified employers". Exchanges also must have security procedures and privacy standards necessary to receive tax data and other information needed for enrollment.
- **Operating Model**. States have options to operate their exchange from an "*active purchaser*" model, in which the exchange operates as large employers often do in using market leverage and the tools of managed competition to negotiate product offerings with insurers, to an "*open marketplace*" model, in which the exchange operates as a clearinghouse that is open to all qualified insurers and relies on market forces to generate product offerings. States should provide comparison shopping tools that promote choice based on price and quality and enable consumers to narrow plan options based on their preferences.
- **Small Business (SHOP) Exchanges**. Federal rules will provide a framework for SHOP Exchanges, including options for how employers can provide contributions toward employee coverage that meet standards for small business tax credits. States are permitted to define "small employers" as employers with one to 50 employees for plan years beginning before January 1, 2016. States with differing legal standards for counting employer size should review their definitions for consistency with federal law.
- **Risk Adjustment**. Federal rules in 2011 will outline *risk adjustment methods* and require all health plans to report demographic, diagnostic, and prescription drug data. Further guidance addressing risk adjustment rules and formulas will be provided in subsequent regulations. As specified by the law, federal rules will apply risk adjustment consistently to all plans in the individual and small group markets, both inside and outside of exchanges. Federal rules on reinsurance payments will apply to all plans in the individual market, and rules on risk corridors will apply to all qualified health plans in the individual and small group market, as specified in the law.

FY 2011 TASKS				
AMERICAN HEALTH BENEFITS EXCHANGES				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**FY2011 Actions**	CLARIFICATION AND POLICY GUIDANCE (BASED ON HHS GUIDANCE RELEASED NOVEMBER 17, 2010) (CONTINUED) ▪ **Performance Measures**. Standardized public data reporting will be used to evaluate exchange performance and assure transparency. ▪ **State Choices**. Federal rules will clarify that the following policy areas, among others, are State decisions, although HHS may offer recommendations and technical assistance to States as they make these decisions: 1. Whether to form the exchange as a governmental agency or a non-profit entity, 2. Whether to form regional exchanges or establish interstate coordination for certain functions, 3. Whether to elect the option under the ACA to use 50 employees as the cutoff for small group market plans until 2016, which would limit access to exchange coverage to employer groups of 50 or less, 4. Whether to require additional benefits in the exchange beyond the essential health benefits, 5. Whether to establish a competitive bidding process for plans, 6. Whether to extend some or all exchange-specific regulations to the outside insurance market (beyond what is required in the ACA). ▪ **State Authority**. The federal government will work with the Governor of the State as the chief executive officer unless authority to operate the exchange has been delegated to a specific authority through state law.

FY 2011 TASKS				
AMERICAN HEALTH BENEFITS EXCHANGES				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**FY2011 Actions**	**PLANNING FOR STATE EXCHANGE IMPLEMENTATION IN FY2014** *(continued)* **FUNDING OPPORTUNITY** **§ 1311 AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS *(STATE PLANNING GRANTS)*** ▪ Authorizes the Secretary of Health and Human Services to award grants to states to support planning efforts in the establishment of the American Health Benefit Exchange. ▪ Grants must be awarded within one year of enactment of the Affordable Care Act, March 2011. ▪ The amount of the grants to each state will be determined by the secretary. ▪ Planning grant recipients may renew the grant if the recipient— 1. is making progress toward establishing an Exchange; and implementing the insurance reforms that comply with the provisions within the health reform law; and 2. is meeting any benchmarks as established by the Secretary. **No grants may be awarded after January 1, 2015.**
☐	☐	☐	**FY2011 Actions**	**FUNDING OPPORTUNITY** **EARLY INNOVATORS GRANT** ▪ Announcement released by OCIIO[2] October 29, 2010. ▪ Provides competitive incentives for states to design and implement the Information Technology (IT) infrastructure needed to operate Health Insurance Exchanges - new competitive insurance market places that will help Americans and small businesses purchase affordable private health insurance starting in 2014. ▪ This competitive "Early Innovators" grant announcement will reward States that demonstrate leadership in developing cutting-edge and cost-effective consumer-based technologies and models for insurance eligibility and enrollment for Exchanges. These "Early Innovator" States will develop Exchange IT models, building universally essential components that can be adopted and tailored by other States. The innovations produced from this Cooperative Agreement will be used to help keep costs down for taxpayers, States, and the Federal Government. The systems developed through these Cooperative Agreements will complement the health plan information on HealthCare.gov. Two-year grants will be awarded by February 15, 2011 to up to five States or coalitions of States that have ambitious yet achievable proposals that can yield IT models and best practices that will benefit all States. These States will lead the way in developing consumer-friendly, cost-effective IT systems that can be used and adopted by other States and help all States and the Federal government save money as they work to develop these new competitive market places.

[2] OCIIO-Office of Consumer Information and Insurance Oversight.

FY 2011 TASKS

AMERICAN HEALTH BENEFITS EXCHANGES

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**FY2011 Actions**	**Rules** **FEDERAL FUNDING FOR MEDICAID ELIGIBILITY DETERMINATIONS AND ENROLLMENT ACTIVITIES PROPOSED RULES** ▪ CMS proposed rules were released November 3, 2010. ▪ Comment period 60 days. ▪ Provides an enhanced FFP of 90 percent for state expenditures for design, development, installation or enhancement of systems until calendar year 2015. ▪ Provides an enhanced FFP of 75 percent for maintenance and operation of systems before 2015 if the system already meets standards and after 2015 for systems that have just become compliant. Newly developed standards will build upon the work of the Medicaid Information Technology Architecture (MITA) (see resource documents, **MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE (MITA)**—framework documents)

FY 2011 TASKS

AMERICAN HEALTH BENEFITS EXCHANGES

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**FY2011 Actions**	**RESOURCE DOCUMENTS** ▪ **HHS INITIAL GUIDANCE TO STATES ON EXCHANGES NOVEMBER 18, 2010—** http://www.ncsl.org/documents/health/1118ExchGuid.pdf ▪ **NATIONAL ASSOCIATION OF INSURANCE COMMISSIONER** "*American Health Benefit Exchange Model Act*" adopted 11/22/10, http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf ▪ **STATE PLANNING GRANTS—"EARLY INNOVATOR"** grants competitive funding to design and implement the information technology (IT) infrastructure needed to operate Health Insurance Exchanges. **1.** announcement released October 29, 2010- http://www.ncsl.org/documents/health/InstEIgrts.pdf **.** 2. grant application package- http://www.ncsl.org/documents/health/EarlyInovGrts.pdf . ▪ **GUIDANCE FOR EXCHANGE AND MEDICAID IT SYSTEMS, VERSION 1.0—** http://www.cms.gov/apps/docs/Joint-IT-Guidance-11-3-10-FINAL.pdf **.** ▪ HHS Memorandum: **Federal Support and Standards for Medicaid and Exchange Information Technology Systems** http://www.healthcare.gov/center/letters/improved_it_sys.pdf . ▪ **FEDERAL FUNDING FOR MEDICAID ELIGIBILITY DETERMINATIONS AND ENROLLMENT ACTIVITIES PROPOSED RULES—** http://www.ofr.gov/OFRUpload/OFRData/2010-27971_PI.pdf . ▪ **MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE (MITA)**—framework documents are available to the public at http://www.cms.gov/MedicaidInfoTechArch/ .

FY 2011 TASKS				
Fraud, Waste and Abuse				
NOT STARTED	IN PROGRESS	COMPLETED	EFFECTIVE DATE	
				Legislators should consider the potential financial impact of noncompliance with fraud, waste, and abuse provisions in the Affordable Care Act.
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** **§6402. FUNDING TO FIGHT FRAUD, WASTE, AND ABUSE.** ▪ Amends provisions in the Social Security Act pertaining to the Health Care Fraud and Abuse Control Account by adding additional funding of $95 million for FY 2011, $55 million for FY 2012, $30 million for FY 2013 and 2014, and $20 million for FY 2015 and 2016. ▪ The additional funding will be allocated for use by the Departments of Health and Human Services and Justice for their fraud and abuse control programs, and for the Medicare Integrity Program. ▪ The additional funding will also support Medicaid Integrity Program activities. **LEGISLATIVE CONSIDERATIONS** ▪ The Department of Health and Human Services Office of the Inspector General has released their plans for FY 2011 which will include a review of State Medicaid agencies' program integrity activities. They will examine state policies and procedures required by the federal regulations at 42 CFR pt. 455 to identify best practices and verify which procedures are operating as intended. Medicaid program integrity includes identifying payment risks, implementing actions to minimize the risks, and identifying and collecting overpayments.
☐	☐	☐	**FY 2011**	**ISSUE** **§10201. WAIVER TRANSPARENCY. -** Applies to applications for or renewal of experimental projects, pilots or demonstration projects under Section 1115 of the Social Security Act. **RESOURCE DOCUMENTS** ▪ **CMS Proposed Rules** released September 17, 2010, http://edocket.access.gpo.gov/2010/pdf/2010-23357.pdf
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** **§6402. ENHANCED MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.** ▪ **Overpayments -** Requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report was due, whichever is later. The ACA also provides that failure to return an overpayment within the timeframe is considered an "obligation" under the False Claims Act ("FCA") and could lead to liability for additional penalties if a FCA violation is found to exist. ▪ **National Provider Identifier -** Requires the Secretary to issue a regulation mandating that all Medicare, Medicaid, and CHIP providers include their NPI on enrollment applications. ▪ **Medicaid Management Information System** - Authorizes the Secretary to withhold the Federal matching payment to States for medical assistance expenditures when the State does not report enrollee encounter data in a timely manner to the State's Medicaid Management Information System (MMIS).

FY 2011 TASKS

FRAUD, WASTE AND ABUSE

NOT STARTED	IN PROGRESS	COMPLETED	EFFECTIVE DATE	
☐	☐	☐	**To be published in the final rule in FY2011**	ISSUE **§6411. EXPANSION OF THE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM -** Requires States to establish contracts with one or more Recovery Audit Contractors (RACs). These state RAC contracts would be established to identify underpayments and overpayments and to recoup overpayments made for services provided under state Medicaid plans as well as state plan waivers. RESOURCE DOCUMENTS ▪ **CMCS Informational Bulletin** (CPI-B 11-03) February 1, 2011, http://www.cms.gov/MedicaidIntegrityProgram/Downloads/6411racdelay.pdf . ▪ **The CMS** state Medicaid Directors letter October 1, 2010- http://www.cms.gov/smdl/downloads/SMD10021.pdf. ▪ **CMS Proposed Rules** released November 10, 2010, http://edocket.access.gpo.gov/2010/pdf/2010-28390.pdf.
☐	☐	☐	**Jan. 1, 2011**	ISSUE **§6501. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID - IF TERMINATED UNDER MEDICARE OR OTHER STATE PLAN -** Requires States to terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another state's Medicaid program.
☐	☐	☐	**Jan. 1, 2011**	ISSUE **§ 6502. MEDICAID EXCLUSION FROM PARTICIPATION RELATING TO CERTAIN OWNERSHIP, CONTROL, AND MANAGEMENT AFFILIATIONS.** Requires Medicaid agencies to exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that: (1) has failed to repay overpayments during the period as determined by the Secretary; (2) is suspended, excluded, or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.
☐	☐	☐	**Jan. 1, 2010**	ISSUE **§ 6504. REQUIREMENT TO REPORT EXPANDED SET OF DATA ELEMENTS UNDER MMIS TO DETECT FRAUD -** Requires states and Medicaid managed care entities to submit data elements from MMIS as determined necessary by the Secretary for program integrity, program oversight, and administration.
☐	☐	☐	**As determined by the Secretary.**	ISSUE **§ 6505. PROHIBITION ON PAYMENTS TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES -** Prohibits states from making any payments for items or services provided under a Medicaid state plan or waiver to any financial institution or entity located outside of the United States.

FY 2011 TASKS				
FRAUD, WASTE AND ABUSE				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** **§ 6506. OVERPAYMENTS -** Extends the period for states to repay uncollected overpayments to one year; states are still required to repay collections in the period collected. When overpayments due to fraud are pending a final determination of the amount of the overpayment due to an ongoing judicial or administrative process, state repayments of the Federal portion would not be due until 30 days after the date of the final judgment. **RESOURCE DOCUMENTS** **The Centers for Medicare and Medicaid Services** memorandum July 13, 2010, *Extended Period for Collection of Provider Overpayments,* http://www.cms.gov/smdl/downloads/SMD10014.pdf
☐	☐	☐		**ADDITIONAL RESOURCES** ▪ **Presentation from the National Association for Medicaid Program Integrity Conference:** Angela Brice-Smith, Director, Medicaid Integrity Group, Center for Program Integrity, Centers for Medicare and Medicaid Services, http://www.nampi.org/members/2010presentations/MIGUpdate.pdf.

FY 2011 TASKS

Health Care Facilities & Workforce

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**July 1, 2011**	**ISSUE** **§ 5503. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.** ▪ Beginning July 1, 2011, the secretary is directed to redistribute unfilled residency positions allotted for payment under the graduate medical education program, if they have been unfilled for three cost reports, and convert them for training of primary care physicians. ▪ Grants an exception to hospitals in rural areas with fewer than 250 acute care inpatient beds and hospitals that are part of a qualifying entity which had a voluntary residency reduction plan approved.
☐	☐	☐	**FY 2011**	**ISSUE** **§ 340H. PROGRAM OF PAYMENTS TO TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.** ▪ Creates a new section of the Public Health Service Act requiring HHS to make payments for direct and indirect costs to qualified teaching health centers (THCs) for the expansion of existing or the establishment of new approved graduate medical education (GME) training programs. ▪ Payments will be in addition to GME payments and will not count against the limit in number of full-time equivalent residents paid for by Medicare or Children's Hospital GME Programs. ▪ Payments are to be reduced by 25 percent if the THC fails to report certain information. ▪ Appropriates for this purpose may not exceed $230 million, for the period of FY2011 through FY2015.

FY 2011 TASKS

HEALTH CARE FACILITIES & WORKFORCE

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**FY2011**	**ISSUE** *(FUNDING)* **§ 10503. COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS FUND.** ▪ Creates the Community Health Center Fund. ▪ Appropriates $1 billion for FY 2011, for community health center operations and patient services, and ▪ Also appropriates $1.5 billion for health center construction and renovation to be available for FY2011 through FY2015 and remain available until expended. ▪ Applications were accepted beginning August 9, 2010 through January 7, 2011. ▪ Projected award date August 2011.
☐	☐	☐	**Dec. 31, 2011**	**ISSUE** **§ 6102. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES AND NURSING FACILITIES.** ▪ Directs HHS to establish and implement a quality assurance and performance improvement program for Medicare and Medicaid skilled nursing facilities (SNFs) and nursing facilities (NFs), including multi unit chains of facilities. ▪ Calls for the establishment of standards relating to quality assurance and performance improvement. ▪ Facilities must develop and submit a plan to meet these standards to HHS by the end of FY 2015.
☐	☐	☐	**FY 2011**	**ISSUE** **§ 1109. PAYMENT FOR QUALIFYING HOSPITALS.** ▪ Increases Medicare payments to acute care hospitals in low-cost counties by $400 million for fiscal years 2011 and 2012. ▪ Qualifying hospitals must be located in counties ranked in the lowest quartile of adjusted Medicare Part A and B benefit spending. ▪ Payments will be in proportion to its Medicare inpatient hospital payments relative to Medicare inpatient hospital payments for all qualifying hospitals.

FY 2011 TASKS				
HEALTH CARE FACILITIES & WORKFORCE				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**Deadline Sept. 30, 2011**	ISSUE [*GRANT OPPORTUNITY*] **§ 10502. INFRASTRUCTURE TO EXPAND ACCESS TO CARE. [hospital construction grants]** ▪ Authorizes $100 million beginning in FY 2010 through to September 30, 2011 for debt service, construction or renovation of: 1. a health care facility that provides research 2. an inpatient tertiary care facility, or 3. an outpatient clinical services facility. ▪ The applicable facility must be affiliated with an academic health center at a public research university that contains the state's sole public academic medical and dental school. ▪ To be eligible the governor of a state must submit an application to HHS that certifies that the new facility is critical for the provision of greater access to care, the facility is essential to the viability of the schools, the additional support would be no more than 40 percent of the total cost, and the state has established a dedicated funding mechanism necessary to complete the project.

FY 2011 Tasks				
Insurance Reform				
Not Started	**In Progress**	**Completed**	**Implementation Date**	
☐	☐	☐	**FY2011** Standards developed within 12 months of enactment. Implement use of documents within 24 months of enactment.	**Issue** **§1001 Development and Utilization of Uniform Explanation of Coverage Documents and Standardized Definitions.** ▪ Directs HHS to develop standards within 12 months of enactment for summaries and benefits information to be used by health insurers to inform beneficiaries of their insurance coverage. ▪ Noncompliance by health insurers will result in a fine of $1000 per incident. Applies to all health insurers. **Legislative Considerations** ▪ May preempt state law if the state requirements provide less information than is required in the Affordable Care Act. ▪ Analyze and conform as necessary state laws relating to required plan information distributed to health insurance beneficiaries.
☐	☐	☐	**Jan. 1, 2011**	**Issue** **§1001 Bringing Down the Cost of Health Care Coverage (Medical Loss Ratio [MLR]).** ▪ Requires health insurance issuers (group, individual, and grandfathered health plans) to report to HHS annually their ratio of incurred loss (claims) plus the loss adjustment expense (change in contract reserves) to earned premiums. The report must include total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that the coverage expends: 1. On payment for medical services, 2. For health care quality improvement, 3. On all non-claims costs, excluding federal and state taxes and licensing or regulatory fees. ▪ Issuers will not have to account for collections or receipts for risk adjustment, risk, corridors, and payments of reinsurance until 2014. ▪ Insurers will be required to provide an annual rebate to enrollees if the ratio of the amount of premium revenue expended on costs versus total premium revenue for the plan year is less than 85 percent in the large group market, or 80 percent in the small group market. **Legislative Considerations** ▪ Review state medical loss reporting requirements and harmonize state definitions, application, and scope with those established under federal law. ▪ Conform state law to mirror federal requirements concerning calculation and timing of rebate payments **Resource Documents** ▪ **Interim Final Rule Technical Correction**, 12/30/10, http://edocket.access.gpo.gov/2010/pdf/2010-32526.pdf . ▪ **OCIIO Technical Guidance (OCIIO 2010 – 2A)**: Process to Request an Adjustment to the MLR Standard, 12/17/10, http://www.hhs.gov/cciio/regulations/12-17-2010ociio_2010-2a_guidance.pdf . ▪ **OCIIO Interim Final Rule** posted 11/22/10, http://www.ofr.gov/OFRUpload/OFRData/2010-29596_PI.pdf . ▪ **The National Association of Insurance Commissioners** Regulation adopted 10/21/10, http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf .

FY 2011 TASKS				
LONG-TERM CARE				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	Jan. 1, 2011	ISSUE **§ 8002. COMMUNITY LIVING ASSISTANCE SERVICE AND SUPPORTS.** ▪ Establishes a new, voluntary, self-funded public long-term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations. Requires the Secretary to develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides cash benefit that is not less than an average of $50 per day. No taxpayer funds will be used to pay benefits under this provision. ▪ Creates a new national insurance program to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities. ▪ Financed through voluntary payroll deductions (with opt-out enrollment similar to Medicare Part B), this program will remove barriers to independence and choice (e.g., housing modifications, assistive technologies, personal assistance services, transportation) by providing a cash benefit to individuals unable to perform two or more functional activities of daily living. *DEFINITIONS* ▪ "Active enrollee" means an individual who has enrolled and paid premiums to maintain enrollment. "Activities of daily living" include eating, toileting, transferring, bathing, dressing, and incontinence or the cognitive equivalent. ▪ An "eligible beneficiary" has paid premiums for at least 60 months and for at least 12 consecutive months. (§ 3203) *CLASS INDEPENDENT BENEFIT PLAN* ▪ Directs the Secretary of Health & Human Services to develop two alternative benefit plans within specified limits. ▪ The monthly maximum premiums will be set by the Secretary to ensure 75 years of solvency. ▪ There is a five year vesting period for benefit eligibility. ▪ The benefit triggers when an individual is unable to perform not less than two activities of daily living for at least 90 days. ▪ The cash benefit will be not less than $50 per day. ▪ Not later than October 1, 2012, the Secretary will designate a CLASS benefit plan, taking into consideration the recommendations of the CLASS Independence Advisory Council.

FY 2011 TASKS			
LONG-TERM CARE			
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE
☐	☐	☐	Jan. 1, 2011

ISSUE

§ 8002. COMMUNITY LIVING ASSISTANCE SERVICE AND SUPPORTS. *(continued)*

ENROLLMENT AND DISENROLLMENT

- The Secretary will establish procedures to allow for voluntary automatic enrollment by employers, as well as alternative enrollment processes for self-employed, employees of non-participating employers, spouses and others. Individuals may choose to waive enrollment in CLASS in a form and manner to be established by the Secretary. **Employees must opt-out of the program or they will be enrolled automatically**.
- Premiums will be deducted from wages or self-employment income according to procedures established by the Secretary.

BENEFITS

- Eligible beneficiaries will receive appropriate cash benefits to which they are entitled, advocacy services, and advice and assistance counseling.
- Cash benefits will be paid into a Life Independence Account to purchase non-medical services and supports needed to maintain a beneficiary's independence at home or in another residential setting, including home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and added nursing support.

CLASS INDEPENDENCE FUND

- The CLASS Independence Fund will be located in the Department of the Treasury and the Secretary of the Treasury will act as the Managing Trustee.
- A CLASS Independence Fund Board of Trustees will include the Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, the Secretary of Health & Human Services, and two members of the public.

CLASS INDEPENDENCE ADVISORY COUNCIL

- The CLASS Independence Advisory Council, created under this Title, will include not more than 15 members, named by the President, a majority of whom will include representatives of individuals who participate or are likely to participate in the CLASS program.
- The Council will advise the Secretary on matters of general policy relating to CLASS

RESOURCE DOCUMENTS

CRS report: **C**ommunity Living Assistance Services and Supports (CLASS) Provisions in the Patient Protection and Affordable Care Act (PPACA), http://www.ncsl.org/documents/health/CLASS.pdf .

FY 2011 TASKS

MEDICAID

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** [*BUDGET ITEM*] **§2006. SPECIAL ADJUSTMENT TO FMAP DETERMINATION FOR CERTAIN STATES RECOVERING FROM A MAJOR DISASTER.** ▪ Reduces projected decreases in federal Medicaid matching funds as a result of the regular updating process, for states that have experienced major disaster. ▪ To qualify as a "disaster recovery FMAP adjustment state", a state must have over the past seven fiscal years received a Presidential declaration of a major disaster under the provisions of sec. 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act **and** every county or Parrish in the state statewide was eligible for both individual and public assistance.
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** *[BUDGET ITEM]* **§2001. STATE FINANCIAL HARDSHIP EXEMPTION.** ▪ Between January 1, 2011 and December 31, 2013, a state is exempt from the maintenance-of-effort for optional non-pregnant, non-disabled adult populations above 133 percent of the federal poverty level if the state certifies to the Secretary that the state is experiencing a budget deficit for the year in which the certification is made or projects to have a budget deficit for a succeeding state fiscal year. **LEGISLATIVE CONSIDERATIONS** ▪ A state may make the necessary certification that they are experiencing a budget deficit on or after December 31, 2010.
☐	☐	☐	**July 1, 2011**	**ISSUE** *[BUDGET ITEM]* **§2005. PAYMENTS TO TERRITORIES.** ▪ Beginning in July 1, 2011 through September 30, 2019, all territories' FMAP rate and spending caps will be increased. ▪ Requires territories in 2014 to provide coverage to childless adults who met income eligibility standards consistent with those already established for parents by the territories. ▪ Provides that the cost of providing coverage to newly eligible individuals will not count towards the spending cap. *TERRITORIES AND THE HEALTH INSURANCE EXCHANGES* Each territory will have a one-time option to "opt-in" to state (or territory)-based insurance exchanges in 2014.

FY 2011 TASKS				
MEDICAID				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	March 2011	ISSUE **§6401. PROVIDER SCREENING AND OTHER ENROLLMENT REQUIREMENTS UNDER MEDICARE, MEDICAID, AND CHIP.** ▪ Directs HHS in consultation with the Office of the Inspector General to establish procedures for screening of providers and suppliers who enroll in the Medicare, Medicaid, and CHIP programs. ▪ At a minimum the procedures would include a process for screening, enhanced oversight measures, disclosure requirements, moratoriums on enrollment, and requirements for developing compliance programs. ▪ To cover the costs of the screening, certain providers would be subject to fees. Fees would start at $500 for institutional providers and would increase by the rate of inflation thereafter. ▪ The HHS may exempt the fees if they impose a hardship. ▪ Enforcement of compliance of the requirements will begin March 2011 for all new providers in the programs. ▪ Compliance for all current providers will go into effect two years after enactment of the ACA in 2013. LEGISLATIVE CONSIDERATIONS In addition to the requirements listed above, the Office of the inspector general plans to review in their FY 2011 work plan how states ensure that Medicaid managed care plans follow a structured process for credentialing and recredentialing of providers. Regulations at 42 CFR 438.214 require states to ensure that managed care plans serving the Medicaid population implement written policies for selection and retention of providers. Each managed care plan must document its process for credentialing and recredentialing providers that have signed contracts or participation agreements. Plans must not employ or contract with provides excluded from participation in federal health care programs. They will also be examining how CMS ensures that states comply with requirements for provider credentialing by Medicaid managed care plans. RESOURCE DOCUMENT ▪ **CMS Final Rule with Comment Period** February 2, 2011, http://edocket.access.gpo.gov/2011/pdf/2011-1686.pdf . ▪ **CMS Proposed Rule** published September 23, 2010. http://edocket.access.gpo.gov/2010/pdf/2010-23579.pdf ▪ **HHS presentation** during the National Association for Medicaid Program Integrity Conference September 2010, http://www.nampi.org/members/2010presentations/MIGUpdate.pdf.

FY 2011 TASKS				
MEDICAID				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	FY 2011	ISSUE *[DEMONSTRATION]* **§2707. MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT.** ▪ Requires the Secretary of HHS to establish a three-year Medicaid demonstration project in **up to eight states**. ▪ Participating states would be required to reimburse certain institutions for mental disease (IMDs) for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition. *APPROPRIATIONS* ▪ Appropriates $75 million for FY 2011. These funds will remain available for obligation through December 31, 2015. *EVALUATION* ▪ Directs the Secretary to conduct an evaluation to determine the impact of the demonstration project and to make recommendations as to whether the demonstration project should be continued after December 31, 2013 and expanded nationwide. *REPORT TO CONGRESS* ▪ Directs the Secretary to submit a report to Congress no later than December 31, 2013 and make available to the public a report on the findings of the evaluation. RESOURCE DOCUMENT ▪ **Substance Abuse and Mental Health Services Administration** (SAMHSA) document- http://www.samhsa.gov/healthreform/docs/Medicaid_Emergency_Psychiatric_Demo_508.pdf

FY 2011 TASKS				
MEDICAID				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	October 1, 2010	ISSUE **CHANGES TO MEDICAID PAYMENT FOR PRESCRIPTION DRUGS** **§2503. MEDICAID PHARMACY REIMBURSEMENT.** ▪ Changes the Federal upper payment limit (FUL) to no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recent average manufacturer prices (AMPs) for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through retail community pharmacies. ▪ Establishes a new formula for determining AMP based on sales to wholesalers and sales to retail community pharmacies. ▪ Effective on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date. RESOURCE DOCUMENT ▪ **CMS FINAL RULE NOVEMBER 15, 2010—** Medicaid Program; Withdrawal of Determination of Average Manufacturer Price, Multiple Source Drug Definition, and Upper Limits for Multiple Source Drugs HTTP://EDOCKET.ACCESS.GPO.GOV/2010/PDF/2010-28649.PDF ▪ **CMS memo** September 28, 2010, *Revised Policy on Federal Offset of Rebates, http://www.cms.gov/smdl/downloads/SMD10019.pdf*
☐	☐	☐	Jan. 1, 2010	ISSUE **§2501. INCREASE MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS.** ▪ Increases the minimum manufacturer rebate for brand-name drugs purchased by state Medicaid programs from 15.1% of average manufacturer price to 23.1% of average manufacturer price. *Increase Minimum Rebate Percentage for Clotting Factors and Drugs Approved by the FDA for Pediatric Use Only* ▪ Increases the minimum manufacturer rebate for brand-name drugs purchased by state Medicaid programs from 15.1% of average manufacturer price to 17.1% of average manufacturer price. *Application of Rebates to New Formulations of Existing Drugs* ▪ The rebate for line extension drugs will be the greater of the amount computed under the rebate statute or the product of the AMP for the line extension drug multiplied by the highest additional rebate for any strength of the original brand name drug.

FY 2011 TASKS				
MEDICAID				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐		ISSUE **§2501. INCREASE MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS. (CONTINUED)** *Rebates for Drugs Dispensed by Medicaid Managed Care Organizations (MCOs)* ▪ Requires manufacturers to pay rebates for drugs dispensed by Medicaid MCOs, effective March 23, 2010. *Limit on Total Rebate Liability* ▪ Limits total rebate liability on an individual single source or innovator multiple source drug to 100 percent of AMP for that drug product. Other features of the drug rebate program, such as the Medicaid's best price provision, would remain unchanged. RESOURCE DOCUMENT **CMS memo** September 28, 2010, *Revised Policy on Federal Offset of Rebates,* *http://www.cms.gov/smdl/downloads/SMD10019.pdf*

FY 2011 TASKS				
MEDICAID				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	Jan. 1, 2010	ISSUE **§2501. INCREASED REBATE PERCENTAGE FOR GENERIC DRUGS.** ▪ Increases the rebate percentage for non innovator, multiple source drugs to 13% of AMP. RESOURCE DOCUMENT ▪ **CMS memo** September 28, 2010, *Revised Policy on Federal Offset of Rebates,* http://www.cms.gov/smdl/downloads/SMD10019.pdf
☐	☐	☐		ISSUE **§2501. MAXIMUM REBATE AMOUNT.** Increases the amount of rebates that drug manufacturers are required to pay under the Medicaid drug rebate program, with different formulas for single source and innovator multiple source drugs (brand name drugs), noninnovator multiple source drugs (generic drugs), and drugs that are line extensions of a single source drug or an innovator multiple source drug, effective January 1, 2010. The Affordable Care Act also required that amounts "attributable" to these increased rebates be remitted to the Federal government drug. RESOURCE DOCUMENT **CMS memo** September 28, 2010, *Revised Policy on Federal Offset of Rebates,* http://www.cms.gov/smdl/downloads/SMD10019.pdf

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☐	☐	☐	**Oct. 1, 2011**	**ISSUE** *[BUDGET ITEM]* **§2401. COMMUNITY FIRST CHOICE OPTION.** *State Plan Option to Provide Home and Community-Based Attendant Services and Supports* ▪ Establishes an optional Medicaid benefit which allows states to offer community-based attendant services and supports to Medicaid beneficiaries to assist in accomplishing activities of daily living, instrumental activities of daily living, and health related tasks through hands-on assistance, supervision, or cueing in a person-centered plan that is based on an assessment of functional need. ▪ Provides an **enhanced federal matching rate** of an additional six percentage points for reimbursable expenses in the program. ▪ Consider the need for any statutory changes made necessary to accommodate a state plan amendment if your state opts to participate in this program. **RESOURCE DOCUMENT** **National Association of State Units on Aging** (NASUA), LONG-TERM CARE IN BRIEF: Explaining the Medicaid Community First Choice Option, http://www.nasuad.org/documentation/aca/NASUAD_materials/ltcb_communityfirstchoiceoption.pdf.
☐	☐	☐	**Oct. 1, 2011**	**ISSUE** *[BUDGET ITEM]* **§10202. INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES.** ▪ Incentivizes states that undertake structural reforms in their Medicaid programs designed to create home and community based services (HCBS) as a viable alternative to nursing home care with a targeted enhanced FMAP. ▪ States may participate through a waiver or a state plan amendment. ▪ States that choose a SPA would be able to include individuals with incomes up to 300 percent of the maximum Supplemental Security Income payment. ▪ Funding for the nursing home diversion program would be available for five years beginning in 2011.

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☐	☐	☐	Oct. 1, 2011	ISSUE *[BUDGET ITEM]* **§10202. INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES. *(continued)*** *Enhanced Federal Matching Payments* ▪ FMAP increases will be tied to the percentage of a state's LTC services and supports offered through HCBS, with lower increases going to states needing fewer reforms as follows: ▪ States with less than 25 percent of their total Medicaid long-term care expenditures for FY 2009 on HCBS will set their target for spending 25 percent for these services, to be achieved by October 1, 2015. **These states will receive a 5 percentage point increase in their FMAP.** ▪ Other participating states will set their target percentage for HCBS as a percentage of their Medicaid long term services and supports spending at 50 percent, to be achieved by October 1, 2015. **These states will receive a 2 percentage point increase.** ▪ Maintenance of Effort and Other Requirements ▪ States must maintain their eligibility standards, methodologies, or procedures for determining eligibility for these services at levels that are no more restrictive than those in place on December 31, 2010. ▪ Requires that the additional federal funds be used to pay for new or expanded offerings of non-institutional-based long-term services and supports. ▪ Requires states to implement several structural changes to their Medicaid programs within six-months of application, including: ▪ the implementation of a —**no wrong door policy** where beneficiaries may access LTC services and supports through a coordinated network, agency or other statewide system; ▪ the development of conflict-free case management services; and ▪ development of core assessment instruments to determine eligibility for non-institutionally-based long-term services and supports. ▪ Requires state to collect data tracking service use, quality, and outcomes by beneficiaries and their families. *Funding* ▪ $3 billion in federal matching funds will be available to incentivize states for the five-year period between October 1, 2011 and September 30, 2016. ▪ Consider the need for any statutory changes made necessary to accommodate a state plan amendment if your state opts to participate in this program. RESOURCE DOCUMENT ▪ **National Association of State Units on Aging** (NASUA), LONG-TERM CARE IN BRIEF: Explaining the Medicaid Community First Choice Option, http://www.nasuad.org/documentation/aca/NASUAD_materials/ltcb_communityfirstchoiceoption.pdf

FY 2011 TASKS				
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NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	July 1, 2011	**ISSUE** **§2702. PROHIBITS FEDERAL PAYMENTS TO STATES FOR MEDICAID SERVICES RELATED TO HEALTH CARE ACQUIRED CONDITIONS. [HEALTH-CARE ACQUIRED CONDITIONS (HACS)]** ▪ Will be defined by the secretary and consistent with the definition of hospital acquired conditions[3] under Medicare, but would not be limited to conditions acquired in hospitals. ▪ State Medicaid programs that continue to reimburse health care providers for services associated with a health care acquired condition will no longer receive the federal match for those services. ▪ When the Medicare rule affecting claims payment was implemented several states adopted similar reimbursement practices found in the federal rule for hospital claims, some states opted to negotiated agreements with their large hospital systems and the state hospital associations to refrain from billing when these events occurred. **LEGISLATIVE CONSIDERATIONS** ▪ Legislative intervention may be needed to enable state Medicaid agencies to adopt reimbursement practices that restrict payment for health care acquired conditions. ▪ Consider budgetary impact if state Medicaid policies do not conform to CMS requirements for nonpayment. ▪ Legislators may want to consider a hold harmless provision If none exists in state law protecting Medicaid beneficiaries for responsibility of payment for services when an error is made on the part of a provider, either administrative or a practice error that applies to the HAC provisions. **RESOURCE DOCUMENTS** ▪ **National Guideline Clearinghouse** http://www.guideline.gov/resources/hospital-acquired-conditions.aspx

[3] Deficit Reduction Act Sec. 5001. Hospital Quality Improvement: (c) Quality Adjustment in DRG Payments for Certain Hospital Acquired Infections-(1) Amends Section 1886(d)(4) of the Social Security Act by adding language that states that for discharges occurring after October 1, 2008, the diagnosis related group (DRG) assigned may not result in a higher payment based on a secondary diagnosis associated with conditions identified by the secretary that could have reasonably been avoided through the application of evidence-based guidelines. Hospitals will be required to report the secondary diagnosis present on admission of the patient.

FY 2011 TASKS				
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NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	Jan. 1, 2011	ISSUE **§2703. STATE PLAN OPTION PROMOTING HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS.** ▪ Creates a new Medicaid state plan option under which Medicaid enrollees with at least two chronic conditions or with one chronic condition and at risk of developing another chronic condition, could designate a provider as their health home. ▪ Requires qualifying providers to meet certain standards, including demonstrating that they have the systems and infrastructure in place to provide comprehensive and timely high-quality care either in-house or by contracting with a team of health professionals. ▪ The designated provider or a team of health professionals will offer the following services: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; and referral to community and social support services, if relevant and as feasible use health information technology to link such services. ▪ Teams of providers could be free-standing, virtual, or based at a hospital, community health center, clinic, physician's office, or physician group practice. ▪ Directs the state to develop a mechanism to pay the health home for services rendered. The state plan amendment will include a plan for tracking avoidable hospital readmissions and plan for producing savings resulting from improved chronic care coordination and management. *FEDERAL MATCH PAYMENTS* ▪ Provides an **enhanced match of 90 percent** FMAP for two years for states that take up this option. ▪ In addition, small planning grants may be available to help states intending to take up this option. Pre-Recovery Act service match rate. *EVALUATION* ▪ Requires an independent evaluation be conducted after two years to assess the impact of this option on reducing hospital admissions. LEGISLATIVE CONSIDERATIONS ▪ Determine participation in state optional expansions. ▪ Consider cost-savings impact. RESOURCE DOCUMENTS ▪ **CMS Letter to State Medicaid Directors** November 16, 2010 http://www.cms.gov/smdl/downloads/SMD10024.pdf

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☐	☐	☐	**Jan. 1, 2011**	**ISSUE** *[GRANT OPPORTUNITY]* **§2703. STATE PLAN OPTION PROMOTING HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS. [continued]** **PLANNING GRANTS** ▪ Authorizes the secretary to award planning grants to states for development of a new plan option, ▪ Requires a state match equal to pre-Recovery Act service match rate, and authorizes a maximum of $25 million for this purpose.
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** *[GRANT OPPORTUNITY]* **§4108. INCENTIVES FOR PREVENTION OF CHRONIC DISEASE IN MEDICAID. [PROGRAM FOR HEALTHY LIFESTYLES]** ▪ Creates a **grant program for states** to provide incentives to Medicaid beneficiaries who participate in a program to develop a healthy lifestyle. ▪ These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions. ▪ Appropriates $100 million for the program for a five-year period. **RESOURCE DOCUMENTS** ▪ **SAMHSA Fact Sheet,** http://www.samhsa.gov/healthreform/docs/Incentives_Prevention_Chronic_Disease_Medicaid_508.pdf .
☐	☐	☐	**January 1, 2011** publication deadline for core set of standards	**ISSUE** *[GRANT OPPORTUNITY]* **§2701. ADULT HEALTH QUALITY MEASURES.** ▪ Similar to the quality provisions enacted in CHIPRA, directs the HHS Secretary, in consultation with the states, to develop an initial set of health care quality measures specific to adults who are eligible for Medicaid. ▪ Establishes the Medicaid Quality Measurement Program which will expand upon existing quality measures, identify gaps in current quality measurement, establish priorities for the development and advancement of quality measures and consult with relevant stakeholders. ▪ Requires the Secretary, along with states, to regularly report to Congress the progress made in identifying quality measures and implementing them in each state's Medicaid program. ▪ Standardized reporting by the states would begin in 2013. ▪ States will have an opportunity to receive grant funding to support the development, collection, and reporting of quality measures. ▪ Appropriates $60 million for each FY 2010 through 2014. Total funds available for grants-$30 million

				through 2014.
FY 2011 TASKS				
MEDICARE				
NOT STARTED	**IN PROGRESS**	**COMPLETED**	**IMPLEMENTATION DATE**	
☐	☐	☐	**Jan., 1, 2011**	**ISSUE** **§3108. PERMITTING PHYSICIAN ASSISTANTS TO ORDER POST-HOSPITAL EXTENDED CARE SERVICES.** ▪ Adds physician assistances to the list of providers authorized to order (or certify) post-hospital extended care services for Medicare beneficiaries beginning January 1, 2011. ▪ May impact state dual eligible populations. **LEGISLATIVE CONSIDERATIONS** ▪ Conform as necessary the state Medicaid program criteria for authorization of post acute extended care with federal law.
☐	☐	☐	**July 1, 2011**	**ISSUE** **§3113. TREATMENT OF CERTAIN COMPLEX DIAGNOSTIC LABORATORY TESTS.** ▪ Directs HHS to conduct a demonstration project under part B under which separate payments may be made for complex diagnostic laboratory tests[4] to determine the impact on access to and quality of care, health outcomes, and expenditures. ▪ The demonstration project will be conducted over a two-year period beginning July 1, 2011. ▪ Payments may not exceed $100 million. **LEGISLATIVE CONSIDERATIONS** ▪ Consider impact on projected state expenditures for dual eligibles.

[4] "complex diagnostic laboratory tests' are defined as meaning a test: (1)that is an analysis of gene protein expression, (2) topographic genotyping, or a cancer chemotherapy sensitivity assay; (3) that is determined by the Secretary to be a laboratory test for which there is not an alternative test having equivalent performance characteristics; (4) which is billed using a Health Care Procedure Coding System (HCPCS) code other than a not otherwise classified code under such Coding System; (5) which is approved or cleared by the Food and Drug Administration or is covered under title XVIII of the Social Security Act; and (6) is described in section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3))

FY 2011 TASKS				
MEDICARE				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	Jan. 1, 2011	ISSUE **§3114. IMPROVED ACCESS FOR CERTIFIED NURSE-MIDWIFE SERVICES.** ▪ Amends the Social Security Act to increase coverage for certified nurse-midwife services to Medicare beneficiaries from 80 percent to full coverage as of January 1, 2011. LEGISLATIVE CONSIDERATIONS ▪ Consider impact on projected state expenditures for dual eligibles.
☐	☐	☐	Jan. 1, 2011	ISSUE **§3301. MEDICARE COVERAGE GAP DISCOUNT PROGRAM.** ▪ Effective January 1, 2011, the Discount Program will make manufacturer discounts available to applicable Medicare beneficiaries receiving applicable covered Part D[5] drugs while in the coverage gap. ▪ Drug manufacturer will be required to provide to Part D beneficiaries a 50 percent discount for brand-name drugs and biologics at point-of-sale. LEGISLATIVE CONSIDERATIONS Consider impact on projected state expenditures for dual eligibles and State Pharmaceutical Assistance Programs. RESOURCE DOCUMENTS ▪ **CMS memo** to plan sponsors April 30, 2010, Medicare Coverage Gap Discount Program beginning in 2011 https://www.cms.gov/PrescriptionDrugCovContra/Downloads/2011CoverageGapDiscount_043010v2.pdf ▪ **CMS memo** August 3, 2010, http://www.cms.gov/PrescriptionDrugCovGenIn/Downloads/CGDMemo_08.03.10.pdf ▪ **Medicare.gov:** Five Ways to Lower Your Costs During The Coverage Gap, http://www.medicare.gov/health-and-drugs/bridging-the-coverage-gap.aspx ▪ **CMS document**: Bridging the Coverage Gap, http://www.medicare.gov/health-and-drugs/bridging-the-coverage-gap.aspx .

[5] The Medicare Prescription Drug Benefit was enacted into law on December 8, 2003 the law re-designs Part D which establishes the Voluntary Prescription Drug Benefit Program. The Part D program is available for individuals who are entitled to Medicare Part A or enrolled in Medicare Part B. The Part D program became effective January 1, 2006. The prescription drug coverage is subject to an annual deductible, 25 percent coinsurance up to the initial coverage limit, and the greater of $2/$5 or five-percent catastrophic coverage for individuals that exceed the annual maximum true out-of-pocket threshold.

FY 2011 TASKS				
Medicare				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** **§4103. MEDICARE COVERAGE OF ANNUAL WELLNESS VISIT PROVIDING A PERSONALIZED PREVENTION PLAN.** ▪ Amends the Social Security Act to require that Medicare Part B cover once a year, without cost sharing, 'personalized prevention plan services[6],' including a comprehensive health risk assessment. **LEGISLATIVE CONSIDERATIONS** ▪ Consider impact on projected state expenditures for dual eligibles.
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** **§4104. REMOVAL OF BARRIERS TO PREVENTIVE SERVICES IN MEDICARE.** ▪ Amends the Social Security Act to define preventive services covered by Medicare to mean a specified list of currently covered services, including colorectal cancer screening services even if diagnostic or treatment services were furnished in connection with screening ▪ Waives beneficiary coinsurance requirements for most preventive services, requiring Medicare to cover 100% of the costs. ▪ Specifies that services for which no coinsurance would be required are the initial preventive physical examination (IPPE), personalized prevention plan services, any additional prevention service covered under the authority of HHS, and any currently covered preventive service (including medical nutrition therapy, and excluding electrocardiograms) if it is recommended with a grade of A or B by the U.S. Preventive Services Task Force (USPSTF)[7] **LEGISLATIVE CONSIDERATIONS** ▪ Consider impact on projected state expenditures for dual eligibles.
☐	☐	☐		**ADDITIONAL RESOURCE DOCUMENTS** ▪ **Agency on Aging Document: Affordable Care Act Opportunities for the Aging Network,** http://www.aoa.gov/Aging_Statistics/docs/AoA_Affordable_Care.pdf .

[6] "Personalized prevention plan services" means the creation of plan for an individual: (1) that includes a health risk assessment of the individual that is completed prior to or part of the same visit with a health professional; and (2) that takes into account the results of the health risk assessment.

[7] See the U.S. Preventive Services Task Force, http://www.ahrq.gov/clinic/uspstfix.htm .

FY 2011 TASKS				
Quality, Prevention & Wellness				
NOT STARTED	**IN PROGRESS**	**COMPLETED**	**IMPLEMENTATION DATE**	
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** **§3011. NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE.** ▪ Directs the secretary to establish a national strategy for quality improvement in healthcare. ▪ The secretary must collaborate with state agencies responsible for administering the Medicaid and CHIP programs with respect to developing and disseminating strategies, goals, models, and timetables. ▪ The deadline for the initial submission of the strategy is no later than January 1, 2011. *HEALTH CARE QUALITY INTERNET WEBSITE* ▪ Directs the secretary to create an internet website to make public information regarding the national priorities for healthcare quality improvement, agency specific strategic plans, and other pertinent information the secretary deems appropriate. ▪ Implementation must be no later than January 1, 2011. **LEGISLATIVE CONSIDERATIONS** ▪ Consider the state needs for dissemination of information beyond electronic means. **RESOURCE DOCUMENTS** ▪ **OCIIO Interim Final Rules with Request for Comments**, September 23, 2010, http://www.healthcare.gov/center/regulations/prevention/regs.html . ▪ **HHS Proposed National Health Care Quality Strategy and Plan**: http://www.hhs.gov/news/reports/quality/nationalhealthcarequalitystrategy.pdf.

FY 2011 Tasks			
State Employee Benefit Changes			
Not Started	In Progress	Completed	Implementation Date
☐	☐	☐	Jan. 2011

Issue

Title IX—Revenue Provisions.

Imposes various restrictions on tax-advantaged accounts which are used to pay for unreimbursed medical expenses: health care Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs), Health Savings Accounts (HSAs), and Medical Savings Accounts (MSAs).

Legislative Considerations

Analyze and conform as necessary state employee benefit structures with the provisions in the new federal law concerning the following changes:

- **Distribution for medicine qualified only if for prescribed drug or insulin**
  § 9003—Staring in 2011, the PPACA will prohibit using funds from FSA, HAS, and MSA accounts for over-the-counter (OTC) medications (except insulin) unless they are prescribed by a physician beginning taxable years after December 31, 2010.
- **Increases in additional tax on distributions from HSAs and Archer MSAs not used for qualified medical expenses**
  § 9004—Increases the penalties imposed for account withdrawals for nonmedical purposes for those under age 65 in two accounts. The penalty for nonmedical withdrawals from HSAs will increase to 20% from 10%, and the penalty for nonmedical withdrawals from MSAs will increase to 20% from 15%.

Resource Documents

- **IRS Document**: Sample article for organizations to use to reach customers and taxpayers http://www.irs.gov/pub/irs-utl/oc_-_sept-mid_aca_cust_091710.pdf